



## Appendix 8c

### Shoulder Decompression Task and Finish Group meeting, 1 May 2018 Notes of key discussion points

#### Task and Finish Group members

Attendees:		
Philip Ahrens	interim Clinical Director for Trauma, Orthopaedics, Pain and Podiatry	NCL
Duncan Tennant	Consultant Orthopaedic Surgeon	SWL
Nicola Williams (Chair)	GP and Clinical Lead	SWL
Anita Bhatia	GP and Clinical Director B	NEL
Imran Sajid	GP and Chair of Policy Development Group	NWL
Nicholas Mistry	GP and Clinical Lead, Primary Care Tutor, UCL	NCL
Carol Varlaam	Patient Representative	SWL
Apologies		
Mark Moffat	GP and GP Engagement Lead MSK	SEL

#### Also in attendance:

Jane Halpin	Director	Deloitte
Catharine Geldart	Senior Consultant	Deloitte
Mandip Korotana	Programme Manager	Healthy London Partnership
Kunle Awosanya	Project Manager	Healthy London Partnership

#### 1. Welcome from Nicola Williams, Chair of the Task and Finish Group

The Chair welcomed members and outlined the purpose of the meeting. The Chair confirmed:

- the meeting was quorate
- there were no conflicts of interest although it was noted that Philip Ahrens was a Principal Investigator on the CSAW trial.

## 2. Presentation of the evidence review from Jane Halpin and Catharine Geldart

Colleagues from Deloitte presented the draft evidence review which had been circulated in advance to Task and Finish Group members. They confirmed that the evidence review is looking at latest available evidence, policies that exist (there are no policies in London), and the core evidence on which they are based, to support the Task and Finish Group members in forming a London policy. It was noted that this is not a NICE level type of review. Deloitte colleagues also confirmed that the evidence review is draft, and will be updated following discussions at the Task and Finish Group meeting(s).

The key points were presented as follows:

- The evidence review presents the available evidence and current guidance on subacromial shoulder decompression, a surgical procedure used in the management of subacromial shoulder pain in adults.
- Excluded are patients with acute trauma or suspected infection; patients with suspected malignancy, sudden loss of ability to actively raise the arm (suggesting an acute rotator cuff tear) or symptoms suggestive of systemic inflammatory joint disease.
- Shoulder problems are common causes of issues being presented to GPs, and subacromial pain accounts for up to 70% of shoulder pain presentations. Subacromial decompression is typically used in the management of severe and persistent subacromial pain where conservative measures have been unsuccessful. The most common treatment aims are to reduce pain and improve shoulder function.
- Subacromial decompression is a procedure which has been performed increasingly frequently in the UK over recent years despite a lack of high quality evidence to demonstrate its effectiveness.
- In terms of existing policies and national guidelines, there are no existing policies for shoulder decompression across London.
- There are policies in use by other CCGs nationally which are broadly similar in their specifications and appear to be based upon the Commissioning Guide produced by the British Elbow and Shoulder Society (BESS) and British Orthopaedic Association (BOA) in 2014.

The key search questions that evidence was reviewed against are as follows, as agreed with the T&F Group and Chair:

- 1) What evidence is there regarding the effectiveness of subacromial shoulder decompression surgery?
- 2) Is there evidence that subacromial shoulder decompression surgery is superior to non-surgical treatment options?
- 3) Does the evidence suggest specific clinical circumstances where subacromial shoulder decompression surgery would provide therapeutic benefit?

- 4) Are there any comorbid conditions where subacromial shoulder decompression surgery would be indicated?
- 5) Is there any evidence of harm or deterioration in quality of life through not providing subacromial shoulder decompression surgery?

Deloitte colleagues flagged that there is limited high quality evidence in this area, although they noted and included findings from the recent CSAW (Can Shoulder Arthroscopy Work?) trial published in the Lancet.

### 3. Discussion on the evidence: is it robust and of high quality?

The key discussion points were as follows:

- The incidence of shoulder surgery in general has increased since the widespread adoption of arthroscopic techniques although it is questionable whether ASD as a sole procedure has increased in the same way (data presented was until 2010). This may be in part due to how procedures are being coded. ASD itself is a relatively simple procedure.
- Questions around the effectiveness of Arthroscopic Shoulder Decompression predate the CSAW trial, but the trial has added to the body of evidence. It is thought that the increase in this type of surgery has not continued, but available data only extend to 2010.”
- However it was agreed that this is likely to be variation in the numbers of procedures carried out across London.
- The CSAW trial is important but it also did have limitations, with follow up only at six months and outcomes for each of the three groups were not that great overall. It was also noted that the second surgical group was not technically a ‘sham’ surgery, as they had arthroscopy and bursoscopy (i.e. as opposed to just making an incision in ‘sham’ surgery).
- The available research so far is split roughly 50:50 in terms of demonstrating beneficial outcomes from ASD. The results of the on-going Finnish trial (FIMPACT) looking at long-term outcomes from ASD are awaited.
- There is limited understanding of how the procedure works, however from clinical experience of the orthopaedic consultants, there are some patients who receive benefit from the procedure and patient selection is key.
- The systematic reviews are reviewing all the same papers, which are limited by the quality of the trials, and therefore caution needs to be applied when reviewing the results.
- Some of these trials also studied the wrong population, as they included 16 year olds and over 60’s, age groups in which shoulder pain is unlikely to have the same underlying causation. So they may be strong in terms of numbers, but they are not strong in terms of including the right patient group which can therefore skew findings.
- There appears to be some evidence of effectiveness of conservative management, specifically shoulder specific exercise, and non-steroidal bursal injection in addition to this.
- In terms of whether patients will come to harm or experience deterioration of quality of life if subacromial decompression surgery is not provided, there is no evidence available to confirm this. However, all of the evidence seems to have looked at symptomatic improvement over 6 -12 months rather than progression of disease and evidence of harm.
- Whilst most people can get better with physiotherapy, the access and quality of physio is patchy and variable, and delayed referrals to physio can further aggregate the issue.

- There is an issue of variation across London, with some parts of London doing much greater levels of surgery than others.
- Coding is an issue e.g. the procedure may be coded as shoulder decompression at the outset, and even where a different procedure is carried out, the coding is often not updated.

Whilst noting the issues on the strength of high quality available evidence, the Group agreed that the review itself was sufficiently rigorous to proceed to developing a London policy based on current commissioning guidelines and the best available evidence.

#### 4. Drafting the London policy

In terms of the **presentation** of the London policy, the group agreed the following:

- The policy should be called ‘subacromial shoulder pain’, not decompression.
- At the outset, the policy should state that patients with subacromial pain do not require decompression surgery, unless the following criteria (see below) apply.
- The policy is for primary and secondary care clinicians, and those in MSK / interface services.
- The policy should include advice for GPs including:
  - Referring to intermediary services as per NHSE guidance
  - Imaging is not essential for referral (e.g. when referring to MSK services) as the diagnosis is made on clinical grounds
  - Typical patient age range tends to fall between 35 to 55 years
  - Resolution of symptoms is relatively slow whatever treatment path is chosen, with both recovery from decompression surgery and improvement through conservative management taking up to 6 months.
- The algorithm (appendix 3) is very helpful and should be included in the policy.
- There should be a ‘tick box’ criteria to make it easy for clinicians to follow the policy.
- It was agreed that this policy should include a reference to lifestyle and support being offered on weight management, smoking cessation etc similar to that in the other London policies being developed.

In terms of the **treatment criteria**, the Group agreed the following:

- Conservative non operative management (i.e. education, rest, NSAID or other simple analgesia, physiotherapy) should be offered first to all patients presenting with subacromial pain. The definition of ‘conservative management’ was discussed and whether any parameters could be set to define this further i.e. frequency, length and type of physiotherapy. It was agreed that this was not appropriate given that the nature of the physiotherapy will depend on the reason for shoulder pain and local arrangements for access to and provision of services. Success of physiotherapy will also depend on factors such as the motivation and engagement of the patient, patient belief in physio, and the quality and access to physio.
- It was agreed that there should be a statement in the policy about patients engaging / complying with physiotherapy.

- The Group agreed that a bursal injection of steroid or local anaesthetic may give relief from pain and enable better compliance with physiotherapy. If injection is used, this should be limited to two injections.
- It should be clear in the policy that injections can be either in primary, community or secondary care, depending on local services available.
- It was agreed that the South Yorkshire and Bassetlaw CCGs criteria for referral should be used in the London policy with some amendments as follows:
  - Patient has had symptoms for at least 3 months from the start of treatment  
AND
  - Symptoms are intrusive and debilitating (for example waking several times a night, pain when putting on a coat)  
AND
  - Patient has been compliant with conservative intervention (education, rest, NSAIDs, simple analgesia, appropriate physiotherapy) for at least 6 weeks  
AND
  - A bursal injection of steroid or local anaesthetic has been considered (if locally available and acceptable to the patient). If a bursal injection has been used (maximum of 2), patient should have initially responded positively but symptoms have returned despite compliance with conservative management  
AND
  - Referral is at least 8 weeks following the bursal injection (where the injection has been given in primary care)  
AND
  - Patient confirms that they wish to discuss surgical treatment options
- It was agreed that the policy should make it clear that some groups such as lower limb amputees and / or wheelchair users who rely on their shoulders for mobility are an exception and should be referred sooner.
- In using the South Yorkshire criteria, it was agreed to remove the following statement from the policy as this will come under IFR – *‘Primary Subacromial decompression in isolation is not normally funded unless the patient has a massive subacromial spur scoring the muscle and may otherwise require a cuff repair.’*

## 5. Review of draft policy (statements above) against the ethical framework application sheet

The statements and process were reviewed against the key principles and considerations of the ethical framework. The Group agreed that decisions were:

- Rational
- Socially inclusive:
  - It was noted that each CCG will carry out a full equality impact assessment.
  - Some patient groups e.g. amputees and wheelchair bound have a particular dependency on their shoulder function and should be referred sooner rather than later.
  - Ethnic groups from the Asian subcontinent and the Middle East tend to be presenting for this procedure more commonly, often with other chronic conditions e.g. diabetes
- Clear and open to scrutiny

- Taking economic factors into account
- Promote health

## 6. Next Steps

The following key points were noted as part of the discussions, to be raised the London Choosing Wisely steering group, alongside the policy:

- There is inequity of access to intermediary services such as MSK across London
- Access to and the quality of physiotherapy is hugely variable across London, and it was agreed that the standards of physiotherapy across London should be increased.
- It was noted that the cost effectiveness of physiotherapy is largely unknown.

### Actions

- Deloitte will review if there is any GIRFT data on subacromial decompression across London
- Deloitte will review if there is data on costs per capita and cost per procedure

It was agreed that the Task and Finish Group would finalise and sign off the London policy at its next meeting on 22 May.

# Shoulder Decompression Task and Finish Group meeting, 22 May 2018

## Notes of key discussion points

### Task and Finish Group members

Attendees:		
Philip Ahrens	interim Clinical Director for Trauma, Orthopaedics, Pain and Podiatry	NCL
Duncan Tennent	Consultant Orthopaedic Surgeon	SWL
Nicola Williams (Chair)	GP and Clinical Lead	SWL
Anita Bhatia	GP and Clinical Director	NEL
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Also in attendance:

Jane Halpin	Director	Deloitte
Catharine Geldart	Senior Consultant	Deloitte
Mandip Korotana	Programme Manager	Healthy London Partnership
Kunle Awosanya	Project Manager	Healthy London Partnership

#### 1. Welcome from Nicola Williams Chair of the Task and Finish Group

The Chair welcomed members and outlined the purpose of the meeting. The Chair confirmed:

- the meeting was quorate
- reconfirmed that there were no conflicts of interest

#### 2. Review and sign off notes from previous meeting

The notes of the previous meeting on 1 May 2018 were reviewed and agreed as an accurate and a true reflection of the meeting.

#### 3. Review draft London policy

Key comments and discussion points were as follows:

- Wording in the definitions section of the policy was discussed and it was agreed to change the definition title to “subacromial (shoulder) pain syndrome” to make it easier for non-clinicians to understand. The term “subacromial pain syndrome” is increasingly being used by specialists to describe the spectrum of pathologies, although it was noted that “shoulder impingement

syndrome” is well understood by patients and it was agreed to keep reference to this term in the policy.

- The group agreed that the addition of an “Advice to Primary Care” section was helpful and noted the following for this section:
  - Age group: the policy would state that “subacromial pain and impingement syndrome are most typically seen in relatively active patients between 35-60 years of age”.
  - Infection: it should state that deep infection is rare and qualify what this means, and after superficial infection, state that this occurs in less than 1 in 100 patients.
  - The term ‘appropriate’ physiotherapy was discussed. Whilst this is vague and open to interpretation, the Group agreed that it is difficult to specify type of physio for a number of reasons, including variation in access and quality of physio services across London; the type of physio varies across patients; and there are varying levels of patient engagement. On balance, it was agreed to retain ‘appropriate’. It was also noted that there is an NHSE London programme seeking to ensure MSK services are available across London.
- Variation in coding was discussed and whether a recommendation should be made for using particular codes. Whilst it was agreed that diagnostic codes are straightforward, surgical codes are less so. It was agreed that the policy would state that the codes in the policy are recommended, noting that there may be local variation.
- The Group were satisfied with the list of exclusions, although it was noted that it was important to re-state that children are excluded, in the body of the policy as well as in the Commissioning Statement.
- Imaging was discussed and it was agreed that as scanning is not part of the core pathway, the policy does not need to include this. Imaging will be done in triage services and / or by the specialist as required. It was noted that this should not delay patients who need surgery however.
- There was a broader discussion on imaging in primary care and where scans show any abnormalities; this can often result in a referral. Primary care clinicians do not have the specialist skills to interpret the significance of the scan findings. In addition, reports from some diagnostic service suppliers do not highlight clinically significant findings clearly. SWL have tightened their MRI criteria to address this issue (which is present across a range of conditions).
- Amendments to the clinical criteria were agreed as follows:
  - Ensure that the criteria are written in a way that is applicable to primary care for referral and secondary care for treatment.
  - Include a statement to indicate that the patient should be involved in shared decisions about their treatment, applicable to primary and secondary care clinicians.
  - Reword the bursal injection criteria to make clear the duration of benefit of the bursal injection, before a clinician then assesses the next step, for referral or treatment.
- It was agreed that this policy should include a statement on lifestyle factors, in line with the other London policies being developed.

The Group discussed the London shoulder decompression data (appendix one) circulated ahead of the meeting, and whether the London policy would address differences across London. Key discussion points were:



- There is variation of activity, across different parts of London and across hospitals.
- However, caution needed to be exercised given the make-up of different populations in different parts of London.
- The data is not based on tariffs but on PBR, so cost differences are probably related to depth of coding including complications and comorbidities.
- Monitoring should take place to see if there are changes in variation as the new London policy is implemented. It was noted that the London policy will also need to be reviewed given that new research is due to be published in this area. CCGs are expected to monitor and review their policies on a regular basis.
- The IFR process was discussed, which can be used for particular patients that don't fit within the policy but have exceptional circumstances. There was a difference of view on whether these patients should go through IFR. The experience from South West London, who use the Blueteq system where all forms have to go through prior approval, has seen a significant drop in referrals; it seems to deter inappropriate referrals.
- GIRFT data was not available, however, the Group's recommendation to flag variation across London with the GIRFT team will be taken forward through the London Choosing Wisely Steering Group.

#### **4. Agreement on the London policy**

The Chair summarised the key changes to the policy (as above) and Task and Finish Group members confirmed that they were happy to agree the policy on this basis.

#### **5. Review of draft policy against the ethical framework application sheet**

It was agreed that this stood as per discussions at the last meeting.

#### **6. Next steps**

- The draft policy will be updated based on these discussions and circulated to members for final review.
- Members should respond to confirm that they are happy with the final policy, if possible, within 2 working days.
- The final policy will then be circulated to a wide range of stakeholders for feedback on language, ease of use, implementation etc as part of the soft launch / testing phase.
- The final policy will also be sent to Task and Finish Group as part of this phase, for their comment and for them to circulate on to key colleagues.
- The final policy (with any amendments to language or presentation agreed by the Chair following testing) will be presented at the London Choosing Wisely Steering Group meeting on 3 July 2018, for approval of the review process and to ratify the policy.
- The pan London policy will then be sent to the CCGs for approval at their governing bodies and via local processes.