NHS
Dudley
Clinical Commissioning Group

Equality Analysis Form

Subacromial Pain in Adults

Dudley

Project Name:	Subacromial Pain in Adults
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Team:	Equality and Diversity Team
Date completed:	
Version:	2

What is the aim of the project/proposal?

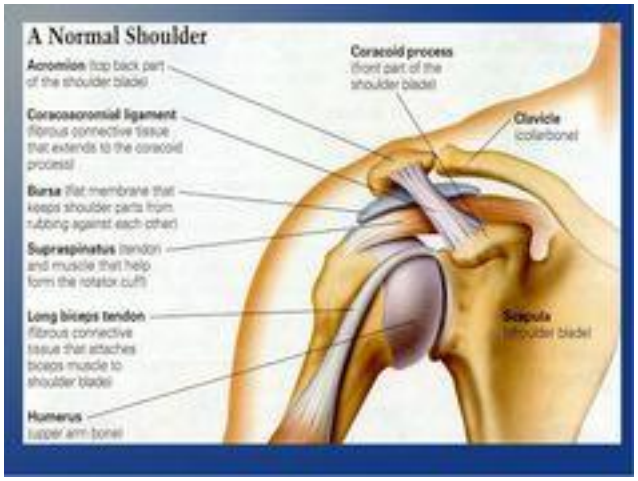
Sub-acromial Pain in Adults

Rotator cuff disease (wear and tear of the rotator cuff tendons) is thought to be a continuum ranging from shoulder impingement syndrome (SIS) through to partial and then full thickness rotator cuff tears [1]. It is one of the most common causes of non-traumatic shoulder pain which presents in primary care and is a normal part of aging [2].

The rotator cuff tendons hold the shoulder joint in place and allow people to lift the arm and reach overhead. When the arm is lifted, the rotator cuff tendon passes through a narrow space at the top of the shoulder, known as the sub-acromial space. The illustration of a healthy shoulder joint below (Figure 1) shows the relationship of tendons, ligaments, soft tissue and bony anatomy of the sub-acromial space.

Arthroscopic sub-acromial decompression is a surgical procedure that involves decompressing the sub-acromial space by removing bone spurs and soft tissue arthroscopically.

Figure 1: Anatomy of a normal shoulder.



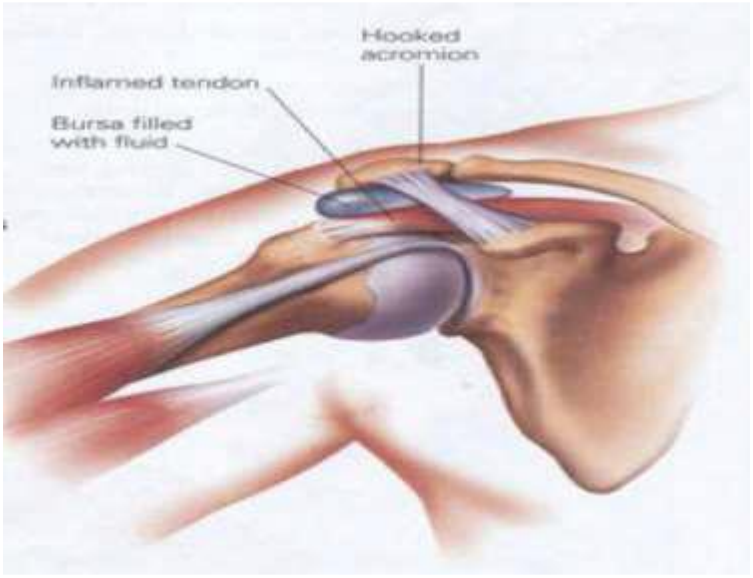
Source: Orthopaedic Surgeons of Long Island Association.

Retrieved from http://www.orthomd.com/procedures/impingement_syndrome.html

Shoulder impingement occurs when the tendon rubs or catches on the acromion and the sub-acromial bursa. Shoulder impingement may start suddenly or come on gradually. As illustrated in Figure 2, it may occur if the tendon is swollen, thickened or torn due to injury, overuse or age-related "wear and tear":

- the subacromial bursa becomes irritated and inflamed (bursitis)
- the acromion is curved or hooked, rather than flat
- there are bony growths (spurs) on the acromion

Figure 2: Anatomy of a shoulder affected by shoulder impingement syndrome



The main problem in shoulder impingement syndrome is of pain in the top and outer side of the shoulder, which is worse when the arm is raised overhead [1]. Pain is associated with dysfunction, affecting usual activities of daily living, sporting activities and ability to work full time. Patients often report a significant reduction in terms of health-related quality of life [3].

Shoulder impingement will often improve in a few weeks or months, especially with

prescribed shoulder exercises.

Arthroscopic Sub-acromial Decompression.

The term ‘arthroscopic’ describes any surgical procedure which is performed using surgical instruments inserted through a small ‘keyhole’ incision and an endoscope inserted via a separate incision to visualise the area.

Arthroscopic shoulder surgery is not one single surgical procedure; rather it refers to a wide range of procedures to different parts of the shoulder anatomy. These may repair damaged cartilage or torn tendons, remove loose fragments of bone or cartilage, drain excess fluid, or release adhesions.

Arthroscopic sub-acromial decompression (ASD) is the most common surgical procedure in patients with shoulder impingement syndrome (SIS) [3]. The standard procedure is antero-inferior acromioplasty, i.e. the resection of bone spurs under the lateral third of the acromion, as well as the excision of the coracoacromial ligament and the sub-acromial bursa. If a partial or small full-thickness tear of the rotator cuff is present, it may be mildly debrided or left alone [3].

Evidence Review

Shoulder Impingement Syndrome

Three randomised controlled trials were identified and reviewed, which compared ASD to conservative treatment for patients with SIS (at 24 months in two of the trials and 12 months only in the CSAW RCT). Patients with partial thickness rotator cuff tears were not excluded from these RCTs. The key differences between the study design were that Ketola et al [7] compared ASD plus physiotherapy to physiotherapy alone [7], whereas in the FIMPACT [6] and CSAW [4] RCTs, there were three treatment arms. Both FIMPACT and CSAW included ASD plus physiotherapy and diagnostic arthroscopy plus physiotherapy as two of the three arms. However, in the UK based multicentre RCT known as CSAW, the third arm was no treatment at all, whereas in the FIMPACT RCT, the non-operative third arm was a home exercise regime as well as 15 hysiotherapy visits.

ASD plus physiotherapy versus diagnostic arthroscopy plus physiotherapy. There was no clinically significant difference between ASD plus physiotherapy treatment compared to diagnostic (sham) arthroscopy plus physiotherapy at either 12-month follow-up in the CSAW RCT [4] or at 24 months (FIMPACT RCT) [6]. This was consistent for all of the outcomes measured: OSS, Constant score, pain, depression and anxiety, quality of life, simple shoulder test,15D and patient satisfaction.

ASD plus physiotherapy versus no treatment: Although small statistical differences were seen in favour of ASD followed by up to four sessions of physiotherapy, there were no clinically important differences for any outcomes measured at 12 months compared to no treatment at all [4].

ASD plus physiotherapy versus physiotherapy therapy only: There were no clinically important differences reported between these two treatment groups at 24-month follow-up [6,7] even though the physiotherapy protocol for the FIMPACT RCT was for 15 sessions (compared to just one post-operative session for those being treated with ASD). Both the ASD plus PT and PT only groups in the RCT by Ketola et al [7] had a similar number of physiotherapy sessions (6 and 7 sessions respectively). Within each treatment group, all three trials showed clinically significant improvements at 12 or 24 months, when compared to baseline for the OSS, the Constant score and for pain [4,6,7].

These RCTs showed that ASD for SIS was no more effective than physiotherapy alone or no treatment at achieving clinically important differences at 12 months and 24 months (OSS, Constant Score and pain). In addition, all three treatment groups achieved clinically important improvements over time compared to baseline. This suggests that the natural history of non-traumatic shoulder impingement syndrome, which has previously failed conservative treatment, is for the painful and disabling symptoms to resolve without intervention.

Supraspinatus Tear

There was one single RCT where 180 patients with a supraspinatus tear were treated with arthroscopic acromioplasty and physiotherapy, or tendon repair, acromioplasty and physiotherapy and the outcomes were compared to patients who had 10 sessions of physiotherapy alone. All the patients followed the same physiotherapy plan. There were no between group differences in the Constant score at 12 months. Although the ASD was performed concomitantly with repair of the supraspinatus tendon, the results are consistent with the results of the RCTs which assessed the effectiveness of ASD for the management of shoulder impingement syndrome.

Cost Effectiveness

No studies generalisable to the NHS were found which measured the cost effectiveness of ASD compared to conservative treatment in patients with subacromial shoulder pain.

Evidence/Guidance/Publications

NHS choices. Shoulder Pain. https://www.nhs.uk/conditions/shoulder-pain/

Artus M, Holt T and Rees J. The painful shoulder: an update on assessment, treatment, and referral. British Journal of General Practice. 2014;64(626), e593-e595.

Chipchase LS, O'Connor DA, Costi JJ, Krishnan J (2000) Shoulder impingement syndrome: preoperative health status. J Shoulder Elbow Surg 9:12–15

Beard DJ, Rees JL, Cook JA CSAW Study Group et al. Arthroscopic subacromial decompression for subacromial shoulder pain (CSAW): a multicentre, pragmatic, parallel group, placebo-controlled, three-group, randomised surgical trial. Lancet 2018;391:329-38.

Linsell L, Dawson J, Zondervan K, Rose P, Randall T, Fitzpatrick R, Carr A. Prevalence and incidence of adults consulting for shoulder conditions in UK primary care; patterns of diagnosis and referral. Rheumatology (Oxford). 2006;45(2):215-21.

Paavola M, Malmivaara A, Taimela S et al. Subacromial decompression versus diagnostic arthroscopy for shoulder impingement: randomised, placebo surgery controlled clinical trial. BMJ 2018;362:k2860

Ketola S, Lehtinen J, Arnala I, et al. Does arthroscopic acromioplasty provide any additional value in the treatment of shoulder impingement syndrome? a two-year randomised controlled trial. J Bone Joint Surg Br 2009;91:1326-34

Ketola S, Lehtinen J, Rousi T et al. Which patients do not recover from shoulder impingement syndrome, either with operative treatment or with non-operative treatment? Subgroup analysis involving 140 patients at 2 and 5 years in a randomised study. Acta Orthop 2015;86:641-46

Ketola S, Lehtinen J, Elo P et al. No difference in long-term development of rotator cuff rupture and muscle volumes in impingement patients with or without decompression. Acta Orthop 2016;87(4):351-55

Ketola S, Lehtinen J, Arnala I. Arthroscopic decompression not recommended in the treatment of rotator cuff tendinpathy. Bone Joint J 2017;99-B:799-805

Kukkonen J, Joukainen A, Lehtinen J et al. Treatment of non-traumatic rotator cuff tears. Bone Joint J 2014;96-B:75-81

Longo UG, Vasta S, Maffulli N, Denaro V. Scoring systems for the functional assessment of patients with rotator cuff pathology Sports Med Arthrosc Rev. 2011;19(3):310-20.doi: 10.1097/JSA.0b013e31820af9b6.

Christiansen DH1, Frost P, Falla D, Haahr JP, Frich LH, Svendsen SW. Responsiveness and Minimal Clinically Important Change: A Comparison Between Shoulder Outcome Measures. J Orthop Sports Phys Ther. 2015 Aug;45(8):620-5.

Constant CR, Murley AH. A clinical method of functional assessment of the shoulder. Clin Orthop Relat Res 1987;214:160–164

Mathieson S, LinC. PainDETECT Questionnaire Clinimetrics. Journal of Physiotherapy 2013 Vol. 59

Stern AF. Questionnaire Review: The Hospitals Anxiety and Depression Score. Occupational Medicine 2014;64:393–394

EuroQol Research Foundation 2018. EQ-5D Instruments. https://euroqol.org/eq-5d-instruments/. Accessed 19.11.2018

National Clinical Coding Standards OPCS-4 (2017) - NHS Digitalhttps://hscic.kahootz.com/gf2.ti/f/762498/27837541.1/.../-/NCCSOPCS42017.pdf

McCormack HM, Horne DJ, Sheather S. Clinical applications of visual analogue scales: a critical review. Psychol Med 1988;18:1007–1019

Beard D, Rees J, Rombach I et al. The CSAW Study (Can Shoulder Arthroscopy Work?)—a placebo-controlled surgical intervention trial assessing the clinical and cost effectiveness of arthroscopic subacromial decompression for shoulder pain: study protocol for a randomised controlled trial.Trials. 2015; 16: 210

Kukkonen J, Kauko T, Vahlberg T et al Investigating minimal clinically important difference for Constant score in patients undergoing rotator cuff surgery. J Shoulder Elbow Surg 2013;22:1650–1655

Salaffi F, Stancati A, Silvestri CA et al. Minimal clinically important changes in chronic musculoskeletal pain intensity measured on a numerical rating scale. Eur JPain 2004;8:283-91

Beard DJ, Carr AJ, Cook JA et al. Can Shoulder Arthroscopy Work? (CSAW) trial –Authors' reply. Lancet. July 28, 2018.

ulkarnhi, R. et al. 2015) Sub-acromial Shoulder pain: BESS/BOA Patient Care Pathways. http://www.bess.org.uk-national guidelines Subacromial Shoulder Pain.pdf

NHS. Shoulder impingement. https://www.nhs.uk/conditions/shoulder-impingement-syndrome/

Who will be affected by this work? E.g. staff, patients, service users, partner organisations etc.

Patients who would wish to access this approach**.**

Eligibility Criteria

Due to the lack of evidence for the clinical effectiveness of arthroscopic shoulder decompression (ASD) compared to conservative treatment, ASD followed by physiotherapy for patients with sub-acromial pain is not routinely commissioned.

N.B. **Acute Severe Shoulder Pain**

- Any shoulder ‘red flags’ identified during primary care assessment need urgent secondary care referral. A suspected infected joint needs same day emergency referral.
- An unreduced dislocation needs same day emergency referral.
- Suspected tumour and malignancy will need urgent referral following the local 2-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.
- Acute calcific tendinopathy is not a red flag, it is severely painful, often mimicking malignant pain and usually necessitates an early secondary care referral for more interventional treatment.
- It should also be noted that patients with subacromial shoulder pain in which the symptoms and signs suggest a more systemic inflammatory joint disease, should be considered as a ‘rheumatological red flag’.
- Any new inflammatory oligo or polyarthritis, with symptoms of inflammation in several joints, should be referred urgently (following local rheumatology referral pathways) because time is of the essence with these diseases and a prompt diagnosis with early commencement of disease modifying drugs where appropriate is essential.

This means the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Activity data:

Number of procedures	Dudley

Is a full Equality Analysis required for this project?

Yes	X	Proceed to the full Equality Analysis form (Next Page)	**No**		Explain why further analysis is not required

Reason why further analysis is not required

If a full assessment is required please ensure that the final version is approved by Neill Bucktin, Director of Commissioning – See Section 9.

EQUALITY ANALYSIS FORM (FULL)

Equality Analysis Form
If at an initial stage further information is needed to complete a section this should be recorded and updated in subsequent versions of the EA. An Equality Analysis is a developing document, if you need further information for any section then this should be recorded in the relevant section in the form and dated.

2. Evidence Used
What evidence have you identified and considered in determining the impact of this decision e.g. census demographics, service activity data, consultation responses
Latest clinical research to ensure the services being commissioned continue to be safe and clinically effective to patients. The restriction of surgery or conservative management will have limited impact on those who would wish to receive the treatments, this must be balanced against the need to adhere to NICE guidelines and the clinical effectiveness evidence. The opportunity for any exceptional cases to be considered via IFR remains and will ensure treatment is available in an exceptional case.
2. Impact of decision
In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.
2.1 Age
Describe age-related impact and evidence. This can include safeguarding, consent and welfare issues.
Age range data is not available for the profile of patients requesting the procedure. Some link may be identified between older patients and increased instances of joint pain, particularly in relation to Osteoarthritis. As the treatment has been not routinely commissioned, those who meet the criteria will be able to access treatment, who are the group who are deemed to benefit most. It is expected that patients not eligible would receive more suitable alternative treatment
2.2 Disability
Describe disability-related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/learning disabilities, cognitive impairments.
As with age pain is itself a life limiting condition and is commonly found as a co morbidity with other conditions. It has not been shown that restricting this treatment will impact on this group negatively since the treatment has not been shown to offer significant benefit. The CCG recognises its obligations to meet the needs of disabled people. The overall intention for this policy since it is NRC is for conservative management to be offered to all patients, but due regard will be given to the CCG's obligations to disabled people.

2.3 Gender reassignment (including transgender)
Describe any impact and evidence in relation to transgender people. This can include issues such as privacy of data and harassment.
No impact identified
2.4 Marriage and civil partnership
Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part time working and caring responsibilities.
No impact identified
2.5 Pregnancy and maternity
Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part time working and caring responsibilities.
No impact identified on the basis of available data
2.6 Race
Describe race-related impact and evidence. This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures and language barriers.
No impact identified
2.7 Religion or belief
Describe any impact and evidence in relation to religion, belief or no belief on service delivery or patient experience. This can include dietary needs, consent and end of life issues.
No impact identified
2.8 Sex
Describe any impact and evidence in relation to men and women. This could include access to services and employment.
No impact identified
2.9 Sexual orientation
Describe any impact and evidence in relation to heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.
No impact identified

2.10 Carers
Describe any impact and evidence in relation to part-time working, shift-patterns, general caring responsibilities. (Not a legal requirement but a CCG priority and best practice)
No impact identified
2.11 Other disadvantaged groups
Describe any impact and evidence in relation to groups experiencing disadvantage and barriers to access and outcomes. This can include socio-economic status, resident status (migrants, asylum seekers), homeless people, looked after children, single parent households, victims of domestic abuse, victims of drug/alcohol abuse. This list is not finite. This supports the CCG in meeting its legal duties to identify and reduce health inequalities.
No impact identified

3. Human Rights		
The principles are Fairness, Respect, Equality, Dignity and Autonomy.		
Will the proposal impact on human rights?	**No**	The decision has been made in line with clinical recommendation
Are any actions required to ensure patients' or staff human rights are protected?	**No**	The patient will have the opportunity to be involved in discussions, decisions and impact about their own healthcare with their GP and has the option for an IFR request to be made.

4. How will you measure how the proposal impacts health inequalities? The CCG has a legal duty to identify and reduce health inequalities

e.g. patients with a learning disability were accessing cancer screening in substantially smaller numbers than other patients. By revising the pathway the CCG is able to show increased take up from this group, this a positive impact on this health inequality.

This condition is not linked to any identified health inequality.

5. Engagement/consultation

What engagement is planned or has already been done to support this project?

Engagement activity	**With who? E.g. protected characteristic/group/community**	**Date**

Please summarise below the key finding / feedback from your engagement activity and how this will shape the policy/service decisions e.g. patient told us, so we will… (If a supporting document is available, please provide it or a link to the document)

As part of the process further targeted engagement is planned with representative groups from among Dudley patients. In addition, it has been identified that patient and clinician information is key in ensuring that the harmonised treatment policies review delivers effective outcomes.

Patient information briefing sheets on each procedure will be developed to give more information on the procedure, eligibility criteria and signposting to further information sources, such as NHS Choices.

The initial drafts of the patient leaflets will be reviewed by a reader panel before the drafts are used as part of the six week engagement process to help people understand the complex treatments described in the policies. This will allow meaningful engagement to enable patients, members of the public and stakeholders to feedback their views on the proposed policy changes.

Once the engagement process has been completed and final decisions have been made on any proposed policy changes, the patient leaflets will then be used to help facilitate discussions between GPs and patients who are to access such services. Leaflets on the agreed policies will be uploaded onto the GP systems for access during such discussions.

Due regard will be given to both the accessible information standard and the potential need to translate such leaflets into relevant local languages.

6. Mitigations and changes
If you have identified mitigations or changes, summarise them below. E.g. restricting prescribing over the counter medication. It was identified that some patient groups require high volumes of regular prescribing of paracetamol, this needs to remain under medical supervision for patient safety, therefore an exception is provided for this group which has resolved the issue.
The CCG will need to review the impact on disabled patients of the operation of this policy and whether further exploration of suitable treatments is required.

7. Is further work required to complete this EA?			
Please state below what work is required and to what section e.g. additional consultation or engagement is required to fully understand the impact on a particular protected group (e.g. disability)			
Work needed	**Sections**	**When**	**Date completed**
e.g. Further engagement with disabled service users to identify key concerns around using the service.	*2 - Disability*	*June - July 2017*	*Sep-17*
Engagement / Consultation: Findings and results of engagement to be added	5	December 2019	

8. Development of the Equality Analysis		
If the EA has been updated from a previous version please summarise the changes made and the rationale for the change, e.g. Additional information may have been received – examples can include consultation feedback, service Activity data		
e.g. Version .01	*The impact on wheelchair users identified additional blue badge spaces are required on site to improve access for this group.*	26-Sep-17

9. Final sign off

Completed EA forms must be signed off by the Director of Commissioning. They will be reviewed as part of the decision making process. Completed forms should be sent to: neill.bucktin@nhs.net so that the CCG can maintain an up to date log of all EAs.	
Version Approved:	