Equality Analysis

(Health Inequalities, Human Rights, Social Value)

Policy for Subacromial Pain in Adults.

Before completing this equality analysis it is recommended that you:

- ✓ Contact your equality and diversity lead for advice and support
- ✓ Take time to read the accompanying policy and guidance document on how to complete an equality analysis

NHS Birmingham and Solihull Clinical Commissioning Group
NHS Sandwell and West Birmingham Clinical Commissioning Group

1. Background

EA Title	Policy for Subacromial Pain in Adults.		
EA Author	David King	**Team**	Equality and Diversity Team
Date Started	13/08/2019	**Date Completed**	13/08/2019
EA Version	2	**Reviewed by E&D**	

What are the intended outcomes of this work? Include outline of objectives and function aims

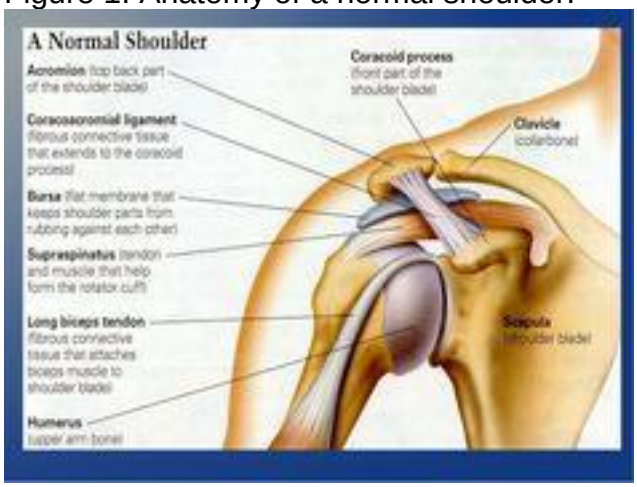
Sub-acromial Pain in Adults

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.

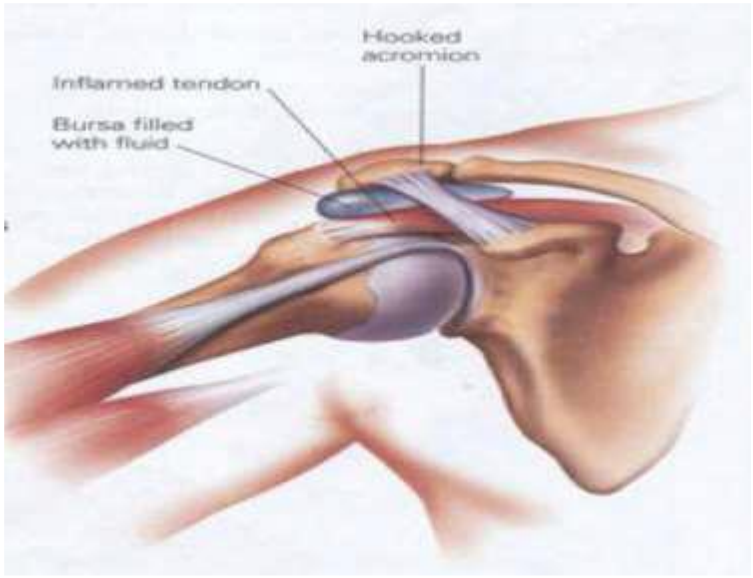


Source: Orthopaedic Surgeons of Long Island Association. Retrieved from http://www.orthomd.com/procedures/impingement_syndrome.html

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.

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	BSOL	Sandwell

2. Research

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.

Research/Publications	**Working Groups**	**Clinical Experts**
Guidance 1. NHS choices. Shoulder Pain. https://www.nhs.uk/conditions/shoulder-pain/ 2. 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.		

3. Chipchase LS, O'Connor DA, Costi JJ, Krishnan J (2000) Shoulder impingement syndrome: preoperative health status. J Shoulder Elbow Surg 9:12–15
4. 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.
5. 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.
6. 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
7. 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
8. 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
9. 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
10. 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
11. Kukkonen J, Joukainen A, Lehtinen J et al. Treatment of non-traumatic rotator cuff tears. Bone Joint J 2014;96-B:75-81
12. 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.
13. 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.
14. Constant CR, Murley AH. A clinical method of functional assessment of the shoulder. Clin Orthop Relat Res 1987;214:160–164
15. Mathieson S, LinC. PainDETECT Questionnaire Clinimetrics. Journal of Physiotherapy 2013 Vol. 59
16. Stern AF. Questionnaire Review: The Hospitals Anxiety and Depression Score. Occupational Medicine 2014;64:393–394
17. EuroQol Research Foundation 2018. EQ-5D Instruments. https://euroqol.org/eq-5d-instruments/. Accessed 19.11.2018

18. National Clinical Coding Standards OPCS-4 (2017) - NHS Digitalhttps://hscic.kahootz.com/gf2.ti/f/762498/27837541.1/.../-/NCCSOPCS42017.pdf
19. McCormack HM, Horne DJ, Sheather S. Clinical applications of visual analogue scales: a critical review. Psychol Med 1988;18:1007–1019
20. 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
21. 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
22. 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
23. Beard DJ, Carr AJ, Cook JA et al. Can Shoulder Arthroscopy Work? (CSAW) trial –Authors' reply. Lancet. July 28, 2018.
24. Kulkarnhi, R. et al. 2015) Sub-acromial Shoulder pain: BESS/BOA Patient Care Pathways.http://www.bess.org.uk/media/Research%20Committee/National%20Guidelines/Subacromial%20Shoulder%20Pain.pdf
25. NHS. Shoulder impingement. https://www.nhs.uk/conditions/shoulder-impingement-syndrome/

3. Impact and Evidence:

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should also include any identified health inequalities which exist in relation to this work.

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.

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:

3. Impact and Evidence:

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.

Gender reassignment (including transgender): Describe any impact and evidence on transgender people. This can include issues such as privacy of data and harassment:

No impact identified

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

Pregnancy and maternity: Describe any impact and evidence on pregnancy and maternity. This can include working arrangements, part-time working, and caring responsibilities:

No impact identified on the basis of available data.

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

Religion or belief: Describe any religion, belief or no belief impact and evidence. This can include dietary needs, consent and end of life issues:

No impact identified

Sex: Describe any impact and evidence on men and women. This could include access to services and employment:

No impact identified

3. Impact and Evidence:
Sexual orientation: Describe any impact and evidence on 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
Carers: Describe any impact and evidence on part-time working, shift-patterns, general caring responsibilities: No impact identified
Other disadvantaged groups: Describe any impact and evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include lower socio-economic status, resident status (migrants, asylum seekers), homeless, looked after children, single parent households, victims of domestic abuse, victims of drugs / alcohol abuse: (This list is not exhaustive) No impact identified

4. Health Inequalities	Yes/No	Evidence
Could health inequalities be created or persist by the proposals?	No	This condition is not linked to any identified health inequality
Is there any impact for groups or communities living in particular geographical areas?	No	No impact identified
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	No	No impact identified
How will you ensure the proposals reduce health inequalities? This condition is not linked to any identified health inequality		

5. FREDA Principles/ Human Rights	Question	Response
Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	Yes, this decision has been made in line with clinical recommendation
Respect – right to have private and family life respected	How will the person's right to respect for private and family life, confidentiality and consent be upheld?	No evidence of impact for this policy

Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	No discrimination identified
	How will this affect a person's right to freedom of thought, conscience and religion?	N/A
Dignity – the right not to be treated in a degrading way	How will you ensure that individuals are not being treated in an inhuman or degrading way?	Policy will be applied with due regard to this consideration.
Autonomy – right to respect for private & family life; being able to make informed decisions and choices	How will individuals have the opportunity to be involved in discussions and decisions about their own healthcare?	An individual can discuss the impact with their GP and has the option for an IFR request to be made
Right to **Life**	Will or could it affect someone's right to life? How?	No evidence of impact for this policy
Right to **Liberty**	Will or could someone be deprived of their liberty? How?	No evidence of impact for this policy

6. Social Value

Consider how you might use the opportunity to improve health and reduce health inequalities and so achieve wider public benefits, through action on the social determinants of health.

Marmot Policy Objective	**What actions are you able to build into the procurement activity and/or contract to achieve wider public benefits?**
Enable all people to have control over their lives and maximise their capabilities	None
Create fair employment and good work for all	None
Create and develop health and sustainable places and communities	None
Strengthen the role and impact of ill-health prevention	None

7. Engagement, Involvement and Consultation

If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:

Engagement Activity	Protected Characteristic/ Group/ Community	Date

For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g. patient told us …. So we will …..):

As part of the process further targeted engagement is planned with representative groups from among Birmingham and Solihull 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. To this end an 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. These information sheets are also designed to help facilitate discussions between GPs and patients. Information briefing sheets have already been tested and uploaded onto the GP systems for the first 45 harmonised treatment policies for Birmingham and Solihull. Due regard will be given to both the accessible information standard and the potential need to translate such leaflets into relevant local languages.

8. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work:

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 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.

9. Mitigations and Changes :

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the **recommendations** and any **changes** to the proposal arising from the equality analysis.

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.

10. Contract Monitoring and Key Performance Indicators

Detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract (refer to NHS Standard Contract SC12 and 13):

This policy is not linked to a contract however, prospective providers remain bound by their contracts with the CCG.

11. Procurement

Detail the key equality, health inequalities, human rights, and social value criteria that will be included as part of the procurement activity (to evaluate the providers ability to deliver the service in line with these areas):

N/A

12. Publication

How will you share the findings of the Equality Analysis?

This can include: reports into committee or Governing Body, feedback to stakeholders including patients and the public, publication on the web pages. All Equality Analysis should be recommended for publication unless they are deemed to contain sensitive information.

Publication on the CCG's website.

Following approval all finalised Equality Analysis should be sent to the Communications and Engagement team for publication: bsol.comms@nhs.net

13. Sign Off

The Equality Analysis will need to go through a process of **quality assurance** by the Senior Manager for Equality and Diversity, Senior Manager for Assurance and Compliance or Equality and Human Rights Manager **and** signed-off by a delegated committee

	Name	Date
Quality Assured By:		
Which Committee will be considering the findings and signing off the EA?		

Minute number (to be inserted following presentation to committee)		

Please send to Balvinder Everitt or Michelle Dunne, Equality, Diversity and Inclusion for Quality Assurance.

Once you have committee sign off, please send to Caroline Higgs, Communications & Engagement Team for publication: bsol.comms@nhs.net