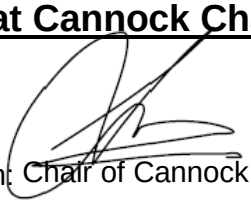
NHS Cannock Chase Clinical Commissioning Group
NHS North Staffordshire Clinical Commissioning Group
NHS South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
NHS Stafford and Surrounds Clinical Commissioning Group
NHS Stoke on Trent Clinical Commissioning Group

Commissioning Policy (Excluded and Restricted Procedures – ERP) For Non-Trauma Musculoskeletal Conditions

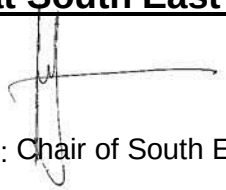
Agreed at Cannock Chase CCG Governing Body

Signature: 

Designation: Chair of Cannock Chase CCG

Date: 02 November 2017

Agreed at South East Staffordshire & Seisdon Peninsula CCG

Signature: 

Designation: Chair of South East Staffordshire & Seisdon Peninsula CCG

Date: 02 November 2017

Agreed at Stafford and Surrounds CCG

Signature: 

Designation: Chair of Stafford & Surrounds CCG

Date: 02 November 2017

Commissioning Policy (Excluded and Restricted Procedures ERP) for Non-Trauma Musculoskeletal Conditions

Version number	V1.9
Responsible Executive Lead	Director of Commissioning
Author(s)	Alexandra Bennett – Head of Commissioning Planned Care – Transformation and Re-design Jackie Newman – IFR Officer
Membership & Locality Boards	Stafford and Surrounds Membership:03 October 2017 Cannock Chase Membership: 10 October 2017 South East Staffordshire & Seisdon Peninsula CCG: Seisdon Locality Board: 11 October 2017 Tamworth Locality: 05 October 2017 Lichfield & Burntwood: 05 October 2017
Date approved by Joint Quality Committee	09 November 2017
Date ratified by Governing Body	02 November 2017
Date issued	10 November 2017
Review date	03 October 2019
Date approved by Equality Impact Assessment	31 December 2016
Target audience	NHS and Private Providers who undertake NHS funded treatment

HISTORY OF CHANGES			
Version Number	**Type of Change**	**Date**	**Description of Change**
V0.1	Initial policy	30/06/2017	Policy development
V0.2	Additions to procedures	21/07/2017	Additional procedures added to policy
V0.3	Final draft for circulation To MS, GF & MH	14/08/2017	
V0.4	MS amendments made	17/8/2017	
V0.5	Amendments from KK, NS & SoT, Spinal & MSK Work stream	19/09/ 2017	Sections:- spinal, hip and knee reviewed and amended
V1	Changes from upper and lower limb T&F groups	02/10/ 2017 03/10/ 2017	Final amendments made.
V1.1 -1.7	Changers from spinal, ortho and task and finish groups	04/10/2017- 24/10/2017	Further amendments made in relation to certain procedures for spinal and shoulder surgery.
V1.8	J Ashworth suggested word changes	31/10/2017	• and feels the patient requires surgery) • rheumatologist or pain consultant is currently treating patient and suspects rotator cuff injury • Patients have received a biopsychosocial assessment within a specialist pain service (ideally multidisciplinary)
V1.9	CC, SAS and SES&SP GB	202/11/2017	MRI wording changed to MRI for Chronic lumbar back-pain (>6 weeks) with no clinical or serological indicators of infection or neoplasia or other red flags to be used in specialist care only where management will be altered.

Commissioning and Business Manager Contacts

Name	Designation
Alex Bennet Alexandra.bennett@staffordandsurroundsccg.nhs.uk	Head of Commissioning, CC, SES&SP and SAS CCGs
Jackie Newman Jackie.Newman2@northstaffs.nhs.uk	IFR Officer, CC, SES&SP and SAS CCGs
Paul Jolley Paul.jolley@northstaffsccg.nhs.uk	Head of Commissioning, North Staffs and Stoke CCGs
Katy Thorpe katythorpe@nhs.net	Business Manager, T&O , Royal Wolverhampton Hospital Trust (RWT)
Claire Powell Claire.Powell@uhnm.nhs.uk	T&O Business Manager, University Hospital North Midlands (UHNM)
Steven Peck Steven.Peck@burtonft.nhs.uk	T&O Interim Business Manager, Burton Hospital (BHT)

Individual Funding Request Contact Details

Name	Designation	CCG
Barry Weaver – ifrteam@nhs.net	Senior Improvement Manager - IFR	Cannock Chase CCG East Staffordshire CCG
David Harrop David.harrop@northstaffs.nhs.uk	IFR Project and Admin Officer	North Staffordshire CCG
Barry Weaver - ifrteam@nhs.net	Senior Improvement Manager - IFR	South East Staffordshire & Seisdon Peninsula
Barry Weaver - ifrteam@nhs.net	Senior Improvement Manager - IFR	Stafford and Surrounds CCG
David Harrop David.harrop@northstaffs.nhs.uk	IFR Project and Admin Officer	Stoke on Trent CCG

Contents

This commissioning policy has been endorsed by and applies to patients within:
NHS Cannock Chase Clinical Commissioning Group (CCG)
NHS North Staffordshire Clinical Commissioning Group (CCG)
NHS South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group (CCG)
NHS Stafford and Surrounds Clinical Commissioning Group (CCG)
NHS Stoke on Trent Clinical Commissioning Group (CCG

1 Policy statement:

Following a review of the evidence and consideration of the local circumstances the six Staffordshire Clinical Commissioning Groups will separately fund (in accordance with this policy):

1.1 Musculoskeletal conditions (MSK) requiring surgical intervention in accordance with defined clinical and process criteria (see page 7&8).

2 Scope of policy

2.1 This policy should be considered in line with all other Staffordshire Commissioning Policies. Copies of these Commissioning Policies are available on the CCGs websites

2.2 This policy relates to surgical procedures and other interventions such as joint injections for the following: lower limb, upper limb* and spinal procedures in both an out-patient and inpatient setting

2.3 This policy should be used in conjunction with the end to end STP MSK pathways for both upper, lower limb and spinal (appendix 1)

2.4 Joint replacement and other interventions for trauma, avascular necrosis (AVN) cancer and red flags **are not** within the scope of this policy

2.5 If the patient is currently under the care of a Consultant Rheumatologist, has exhausted conservative options and requires surgical intervention, the patient can be referred directly to the centre of choice

***Please note that all other MSK related conditions and procedures are contained in the main ERP policy at present.**

3 Background

This policy aims to improve consistency across the whole of Staffordshire and prevent variation in access to NHS Musculoskeletal Services and allows fair and equitable treatment for all of the population we serve.

It also addresses the CCGs statutory responsibility to maintain financial balance and supports decision making in relation to how and where finite local resources are allocated.

The policy is designed to assist CCGs to meet their obligation in providing equitable, affordable access to healthcare and to ensure that patients receive the correct management of care with the best possible outcomes.

The National Service Framework for Musculoskeletal Conditions[1] (2006) identified the need for more robust primary care led medical intervention prior to Orthopaedic and/or Rheumatology (non- inflammatory) referral. This led to the commissioning of Community MSK services which manage the non-surgical pathway.

There are well established services across Staffordshire which currently have an average onward referral rate of 21% to secondary care. Whilst referrals have been significantly reduced across the Staffordshire health economy there are still referrals which may not be suitable or benefit from surgery and are therefore deemed inappropriate.

This policy ensures that all non-surgical interventions have been explored and optimised in conjunction with informed shared decision making. The CCG understands that there will always be a small cohort of patients who need to see an Orthopaedic surgeon to decide whether to have surgery or not and if it is appropriate.

4 Relevant National Guidance and Research

4.1 Evidence

Musculoskeletal (MSK) conditions cover a wide spectrum of conditions across Rheumatology and Orthopaedics and represent a large proportion of both GP and hospital attendances.

[1] http://webarchive.nationalarchives.gov.uk/20130124073659/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4138412.pdf

The evidence for early intervention and appropriate management via primary care and community interface services is vast and represents a significant proportion of the CCGs and local Health Economy (LHE) activity and spend. The need for emergency or urgent referral to an Orthopaedic or Spinal surgeon for Red Flags and certain presentations is also recognised.

The development of this musculoskeletal clinical commissioning policy is based on clinical evidence, clinical guidelines including NICE, research, best practice and expert clinical consensus. The following are the main contributors to the development of this policy, however a more comprehensive reference list can be found in the appendices:-

- National Service Framework for MSK (2006)[2]
- NICE Guidelines (see below) [3]
- British Orthopaedic Association Guidelines[4]
- British Orthopaedic Foot & Ankle Society[5]
- Royal College of Surgeons of England (RCSEng)[6]

All of the organisations have developed evidence based advice to assist commissioning decisions on excluded and/or restricted procedures. In this policy procedures will **ONLY** be funded for patients where they meet specific criteria as stated within the access criteria and that patients have been assessed and received appropriate medical and non-medical interventions within the community Musculoskeletal (MSK) Intermediate Service (MIS) with the exception of Red flags, Cancer and Trauma. Where patients meet the criteria to undergo surgical intervention they must only be referred to secondary care if:

- They have viewed and completed the relevant decision aid tool and agree to surgery
- Are fit for surgery
- They have considered the recuperation period, risk of infection, reduced function, increased pain, altered or loss of feeling, stiffness etc.

Any restricted procedures, as identified within the CCG's Policy on Excluded and Restricted Procedures (ERP) must be approved by the CCG before the surgery can be undertaken. The commissioners' preference is for prior approval to be sought through Blueteq, but alternatively prior approval can be sought by letter or email from the IFR team (see page 3). Commissioners will not pay for any procedures undertaken without the required approval.

5 Commissioning Policy

NHS Cannock Chase, North Staffordshire, South East Staffordshire & Seisdon Peninsula and Stafford & Surrounds and Stoke on Trent Clinical Commissioning Groups,(termed "the Commissioners") consider all lives of all patients whom it serves to be of equal value and, in making decisions about funding treatment for patients, will seek not to discriminate on the grounds of sex, age, sexual orientation, ethnicity, educational level, employment, marital status, religion or disability except where a difference in the treatment options made available to patients is directly related to the patient's clinical condition or is related to the anticipated benefits to be derived from a proposed form of treatment.

---

[2] Http://webarchive.nationalarchives.gov.uk/20130124073659/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4138412.pdf

[3] https://www.nice.org.uk/guidance/cg177; https://www.nice.org.uk/guidance/qs87; https://www.nice.org.uk/guidance/ipg230; https://www.nice.org.uk/guidance/ta304;https://www.nice.org.uk/guidance/ipg408

[4] http://www.boa.ac.uk/pro-practice/commissioning-guides/

[5] https://www.bofas.org.uk/

[6] https://www.rcseng.ac.uk/standards-and-research/nscc/commissioning-guides/topics/

5.1 Surgical Intervention for upper limb, lower limb and spinal conditions involving arthroplasty, arthrodesis and minor surgical procedures relating to Musculoskeletal Conditions

(This policy does not include acute trauma conditions, cancer or trauma)

Surgery will only be funded where **all** of the following **criteria** are met:

5.2 Clinical

- Patient age ≥ 16 years
- Patient has followed the medical pathway and exhausted appropriate non-surgical treatment options
- Have been through and **referred by** a Musculoskeletal Intermediate Service (MIS) or directly from a Rheumatology Consultant or a Pain Consultant who is currently treating the patient and feels the patient requires surgery)
- Patient is willing to undergo surgery and aware that a surgical option is the likely outcome of the referral
- Patient is considered medically fit to undergo surgery and/or opinion is sought in cases were medical fitness is unclear
- Patient meets the clinical criteria for the specific procedure
  (See further within this document)

5.3 Process

- Patient is considered a suitable candidate for onward referral for surgery by primary/community health care professional having followed the medical pathway and all non-surgical options have been exhausted.
- Referral to a surgical provider is received from a Musculoskeletal Intermediate Service (MIS)
- Referral from other routes are to be **rejected** excluding Red Flags and/or Differential Diagnosis (see pathways) or patient who has already had surgery in the same joint
- Adherence to the Local Health Economy MSK pathway
- Prior approval for surgery for restricted procedures in accordance with Prior approval arrangements (Blueteq)
-

This policy will be reviewed and updated on publication of new evidence in the form of relevant trial data, updated national guidance, and national or local audit outcomes.

General practitioners (GPs) and Musculoskeletal Intermediate Services should take account of this policy before considering onward referral. GPs must not refer cases directly to secondary care but refer to the Musculoskeletal Intermediate service (MIS) unless they have a:-

- **Red Flag***
- **Differential Diagnosis (***please refer to specific pathways found in the appendix 1)
- **Have had previous surgery in the affected joint**

Reporting requirements and funding arrangements are detailed on the website (http://sesandspccg.nhs.uk/news-and-information/individual-funding-requests-ifr)

ALL restricted procedures contained within this policy are subject to the CCGs requirement for prior approval. The CCGs preferred method of prior approval is via Blueteq, which will result in a unique approval code being generated. Where providers who do not use Blueteq then requests must be emailed to the relevant CCG secure email address (on page 4) and will be processed by the IFR Team and a unique approval code will be issued.

Providers will **NOT** be paid if the unique approval code is not issued. Retrospective approval is prohibited.

6 Clinically Exceptional Circumstances

If there is demonstrable evidence of a patient's clinical exceptional circumstances, the referring practitioner should refer to the Commissioner's Operational Policy for Individual Funding Requests(IFR) document for further guidance on the process for consideration

And

Where the clinician proposing to undertake the procedure feels that there is a substantial clinical need and that the patient will significantly benefit more than the average patient of the same condition then the referring clinician must present a clear clinical case to the CCG and the IFR form should be used to capture this information. Individual Funding Requests can also be submitted online via Blueteq.

7 Lower Limb

7.1 Hip Pain (OA)

Around 450 patients per 100,000 of the national population will present to primary care with hip pain each year, of these, 25% will improve within three months and 35% at twelve months; this improvement is sustained.

Pain felt around and attributed to the hip can also be due to spinal or abdominal disorders which should be excluded. Hip pathology may cause pain felt only at the knee.

- Degenerative hip disease is the most common diagnosis in the adult and is the long-term consequence of predisposing conditions
- Inflammatory joint disease of the hip may develop at any age, alone or with other joint involvement and may be due to auto-immune disease
- Osteoarthritis (OA) of the hip describes a clinical syndrome of joint pain accompanied by varying degrees of functional limitation and reduced quality of life
- Osteoarthritis may not be progressive and most patients will not need surgery, with their symptoms adequately controlled by non-surgical measures. Symptoms progress in 15% of patients within 3 years and 28% within 6 years
- Hip preserving operations to include impingement and osteotomy for malalignment, to prevent early osteoarthritis in young adults, should be undertaken in Centres performing high volumes of surgery in this cohort of patients (BOA et al. 2013). Whilst there is no definitive number that a surgeon should be doing it is recommended that the number for hip and knee replacements per surgeon, per annum is a minimum of 35 which demonstrates better outcomes. The Getting it Right First Time (GIRFT 2015) identified that the average number of procedures per surgeon per annum was 52 with 24% of surgeons undertaking 10 or less per annum
- Total Hip Replacement (THR) is cost effective, returning 90% of patients to their previous job, and enabling the elderly to keep independent. The National Tariff for THR is cheaper than long-term conservative treatment for osteoarthritis of the hip (Commissioning Guide 2013)
- Patients with a BMI of **35 or more** must be actively supported to engage with local weight management programmes to reduce their BMI
- Joint replacement and other interventions for trauma, avascular necrosis (AVN),cancer and Red Flags **are not** within the scope of this policy

NB: - GIRFT (2015) https://www.boa.ac.uk/wp-content/uploads/2015/03/GIRFT-National-Report-Mar15..pdf

7.1.1 Hip Procedures

OPCS Codes	Hip Condition/Procedure	Threshold	Status
W871 W878 W879	**Diagnostic Arthroscopy of Hip**	The CCGs do not commission diagnostic arthroscopy	**Excluded**
W871 W878 W879	**Therapeutic Arthroscopy of the Hip**	This is not routinely commissioned and patients must have:- • Been triaged or seen in the Musculoskeletal Intermediate Service (MIS) • Have exhausted **all** appropriate non-surgical interventions	**Restricted**
Primary total hip replacement with or without cement W3712, W371 , W379 , W381 , W389, W391, W399, W931, W939, W941, W949, W951, W959 **Total prosthetic replacement of the hip, with or without cement, Bilateral** All above codes with Z941 As in primary hip replacement with code Z941 for bilateral operations **Secondary OPCS:** **Bilateral:** Z94.1: Z94.2: Z94.3: **Unilateral:** Z94.2: Z94.3: Z94.4: **Primary ICD-10:** M15: M16: **Complex primary total hip replacement (including bone grafting or femoral osteotomy)** - W3713 **Hip resurfacing arthroplasty** W3715 W581 with Z843	**Primary Total Hip Replacement** Arthritic hip with severe acetabular bone loss, abnormal anatomy (such that non-standard implants may be necessary), prior fusion and cases secondary to infection should be undertaken in specialised centres such as University Hospital of North Midlands (UHNM) Royal Orthopaedic Hospital (ROH) Coventry & Warwickshire Hospital, Royal National Orthopaedic Hospital (RNOH), or in a DGH by a surgeon with expertise.	The CCG will consider referral for hip replacement if all the criteria below has been met:- **1.** • Been triaged or seen in the Musculoskeletal Intermediate Service (MIS) • Has followed the STP agreed MSK OA Hip Pathway or has had previous surgery in same joint • Has exhausted all appropriate non-surgical interventions • Patient still has a painful irritable and stiff hip interfering with sleep, activities of daily living, work or leisure which has not been controlled with measures above • There is narrowing of the joint space on radiograph • Patients with a BMI of 35 or more must be actively supported to engage in life style modifications including with weight management to reduce their BMI **2.** **OR** • Is a young adult (<40) with persistent hip pain which affects activities of daily living, work or leisure **3.** **OR** • Where joint destruction is rapid and where a delay in	**Restricted**

Hip resurfacing arthroplasty bilateral W3719:W581 with Z843 and Z941		surgery may cause total loss of mobility and independence	
	Hip Impingement – these operations should be undertaken by surgeons with a special interest and expertise in young adult hip problems	• Patients must have been triaged or seen in a Musculoskeletal Intermediate Service (MIS) and onward referred	**Restricted**
	Femoral/pelvic osteotomy These operations should be undertaken in specialised centres such as University Hospital of North Midlands (UHNM), Royal Orthopaedic Hospital (ROH) Coventry & Warwickshire Hospital, Royal National Orthopaedic Hospital (RNOH), or in a DGH by a surgeon with expertise.	**May be considered in:** patients aged <50 years with persistent hip symptoms with abnormalities of femoral and/or acetabular anatomy • Patients must have been triaged or seen in a community Musculoskeletal Intermediate Service (MIS) and onwardly referred	**Restricted**

7.2 Knee Pain (OA)

Osteoarthritis (OA) of the knee describes a clinical syndrome of joint damage resulting in pain accompanied by varying degrees of functional limitation and reduced quality of life. Close to 20% of adults aged 45 and above have sought treatment for Knee Osteoarthritis. The majority of patients present to primary care with symptoms of pain and stiffness, which reduces mobility and with associated reduction in quality of life.

- Osteoarthritis may not be progressive and most patients will not need surgery, with their symptoms adequately controlled by non-surgical measures as outlined by NICE 2017

- When patient's symptoms are not controlled by up to three months of non-operative treatment they become candidates for assessment for joint surgery based on imaging and evidence of severe OA. The decision to have joint surgery is based on the patient's pre-operative levels of symptoms, their capacity to benefit, their expectation of the outcome and attitude to the risks involved. Patients should make shared decisions with clinicians, using decision support tools, of which there are numerous for e.g. https://www.england.nhs.uk/rightcare/shared-decision-making/, https://www.evidence.nhs.uk/Search?om=[{%22ety%22:[%22Patient%20Decision%20Aids%22]},{%22srn%22:[%22NHS%20RightCare%22]}]&ps=50

- Knee replacement is the commonest type of surgery used to treat osteoarthritis. The lifetime risk of requiring joint replacement is 10% and in 2011 approximately 70,000 were implanted in the UK

- Total knee replacement is highly effective in up to 85% of patients providing consistent lasting benefit with 95% 7-19 year joint survival. It is highly cost

effective. However 20% of patients have ongoing symptoms at twelve months following total knee replacement. Therefore the discussion of benefits versus risks is crucial

- Patients with a BMI of 35 or more must be actively supported to engage with local weight management programmes to reduce their BMI

7.2.1 Knee Procedures

OPCS Codes	Knee Condition/Procedure	Threshold	Status
W871 W878 W879	**Diagnostic Arthroscopy of Knee**	The CCGs do not commission diagnostic arthroscopy unless:- • For assessment of severe knee pain(based on a recognised pain scale score) following arthroplasty • Where a detailed understanding of the degree of compartment damage within the knee is required, above that demonstrated by imaging, when considering patients for certain surgical interventions (e.g. high tibial osteotomy)	**Restricted**
Primary OPCS: W82: W83: W85.3: W89.1: W89.2 W83, W85.3, W89.1, W89.2 **Secondary OPCS: (may be present after Primary OPC** Z84.4: Z84.5: Z84.6 **Knee joint Primary ICD-10:** (may be present in any secondary diagnosis for Primary OPCS W82) M15:M17:M23.2:M23.3	**Therapeutic Arthroscopy of OA knee**	**All patients must have** had assessment and appropriate intervention via a Musculoskeletal Intermediate Service (MIS) or been triaged and referred straight on **Knee arthroscopy,** lavage and/or debridement for patients with non-mechanical symptoms is not commissioned **Knee arthroscopy**, lavage and/or debridement will not be routinely funded unless the person has knee osteoarthritis with a clear history of mechanical locking (as opposed to morning joint stiffness, 'giving way' or X-ray evidence of loose bodies) **and/or** • Clear history of intermittent mechanical symptoms e.g. locking that have not responded to non-surgical treatment (**if the knee does not unlock then refer urgently to the appropriate clinic)**	**Restricted**
Primary OPCS: W40.1: W40.9: W41.1: W41.9: W42.1: W42.9: joint O18.1: O18.9:	**Primary Knee replacement**	The CCG will consider referral for knee replacement if all the criteria below has been met:- • Patients must have been triaged or seen in a	**Restricted**

Secondary OPCS: (may be present after Primary OPCS) N/A **Primary ICD-10**: M15: M17		Musculoskeletal Intermediate Service (MIS) and onwardly referred • Have exhausted all appropriate non-surgical options • Have moderate or severe knee pain not adequately controlled after commencement of treatment and appropriate non-surgical management following NICE guidance (NICE cg177) • Patients with a BMI of 35 or more will be actively supported to engage in life style modifications including with weight management to reduce their BMI • All patients must have engaged in a shared decision making process about alternatives, with a view to fully involve them in decisions and their care Patients who do not meet **all** of the criteria above may be considered in the following circumstances:- • Functional disability in the presence of end stage cartilage disease Progressive deformity of the knee (varus/valgus) with functional disability	
Primary OPCS: W52.1: W54.1: W52.9: W54.9: W58.1 **Secondary OPCS:** (may be present after Primary OPCS) Z84.4: Z84.5: Z84.6: **Knee joint Primary ICD-10:** M15: M17:	**Partial Knee replacement –** This involves the replacement of only one compartment of the arthritic knee Partial knee replacement is less common and it is more appropriately commissioned and delivered by specialised units, with experienced surgeons, performing around 10 such procedures within a unit per year (NJR 2017)	As well as the criteria for primary knee replacement patients should have:- • Symptomatic Osteoarthritis predominantly confined to a single joint compartment .	**Restricted**
	Knee Revision Surgery	Commissioners do not routinely fund Modular Rotating Hinge knees	**Excluded**

7.3 Foot and Ankle

More than 29,000 patients nationally are referred from primary care to foot and ankle specialists per year with 'ankle pain'. In Rheumatoid Arthritis (RA), 17% have initial involvement of the hind foot and up to 71% have walking difficulty due to foot problems British Orthopaedic Foot and Ankle Society (BOFAS). The following conditions are covered within this policy: -

- **Hallux valgus** (HV) is common with a standardised prevalence of 28.4% in adults older than 40 years. 8% of General Practitioner consultations for musculoskeletal problems relate to the foot and ankle and of these 28% are for foot pain

- **Flat foot** - Flatfeet are a normal physiological variant affecting 20-30% of the population. However the majority of these will have no symptoms and will not be affected in work or recreational activity and do not require treatment. This policy pertains to those patients who have pre-existing flatfeet that are symptomatic and those with previously normal feet that develop symptomatic flatfeet

Hind foot -

- The majority of hind foot arthritis is post traumatic following fractures or severe sprains and this can affect patients of working age

- Other causes of hind foot arthritis include Rheumatoid Arthritis (RA), other inflammatory arthropathies, metabolic disorders such as haemachromatosis, bleeding disorders and conditions causing deformity including neurological disease

- **Refractory Plantar Fasciitis**
  Heel pain is a common presenting complaint in the foot and ankle. Plantar fasciitis is the most common cause of chronic pain beneath the heel in adults, making up 11–15% of the foot symptoms requiring professional care among adults. It is estimated that 1 in 10 people will develop plantar fasciitis during their lifetime. Plantar fasciitis is more common in middle-aged obese females and young male athletes and is most common in people aged 40-60 years and accounts for about 80% of cases of heel pain. Plantar Fasciitis has been described as painful heel syndrome, chronic plantar heel pain, heel spur syndrome, runner's heel, and calcaneal periostitis
  https://cks.nice.org.uk/plantar-fasciitis#!topicsummary
  http://www.nhs.uk/conditions/heel-pain/Pages/Introduction.aspx

- **Extracorporeal Shockwave Therapy for Refractory Plantar Fasciitis**
  Plantar fasciitis is a painful condition affecting the connective tissue that stretches between the heel and the middle of the foot. It is usually caused by overuse, injury or muscular abnormalities. In extracorporeal shockwave therapy, a machine is used to deliver sound waves to the painful area. It is not known exactly how it works, but it is thought that it might stimulate healing of the fascia. Current evidence on its efficacy is inconsistent.
  Not routinely funded, application by IFR only
  https://www.nice.org.uk/guidance/ipg311

- **Extracorporeal Shockwave Therapy for Refractory Achilles Tendinopathy**
  About 6 in 100 inactive people develop Achilles tendinopathy at some point in their lifetime. However, the chance of it developing is higher in athletes or those who train regularly or do a lot of exercise. It can be a particular problem for some runners.
  https://patient.info/health/achilles-tendinopathy
- In adults aged 21–60 years, the incidence of mid-portion Achilles tendinopathy is around 2.35 per 1,000. The incidence is rising, mainly because more people participate in recreational and competitive sports. Risk factors for tendinopathy include strenuous physical activities such as running and jumping, ageing, diabetes mellitus, obesity, hypertension, dyslipidaemia, rheumatoid arthritis or other inflammatory joint diseases, the use of fluoroquinolone antibiotics, abnormal lower limb anatomy, sports training errors, or poor equipment.
- http://dtb.bmj.com/content/50/8/93.full?keytype=ref&siteid=bmjjournals&ijkey=Py8w8YeWh7NPk
- Achilles tendinopathy is characterised by chronic degeneration of the Achilles tendon and is usually caused by injury or overuse. Symptoms include pain, swelling, weakness and stiffness over the Achilles tendon and tenderness over the heel (insertional tendinopathy).

- Conservative treatments include rest, application of ice, non-steroidal anti-inflammatory drugs, orthotic devices, physiotherapy (including eccentric loading exercises).

- The evidence on extracorporeal shockwave therapy (ESWT) for Achilles tendinopathy raises no current evidence on extracorporeal shockwave therapy (ESWT) for Achilles tendinopathy is inconsistent and limited in quality and quantity. Not routinely funded, application by IFR only. https://www.nice.org.uk/guidance/ipg571

7.3.1 Foot and Ankle Procedures

OPCS Codes	Foot and Ankle Condition/Procedure	Threshold	Status
W79.1, W79.2, W79.9: soft tissue operations on joint of toe; W 15.1, 2, 3, 4, 5, 6, 8, 9: Division of bone of foot (osteotomy of metatarsal, tarsal or phalanx); W 59.1, 2, 3, 4, 5, 6, 7, 8, 9: Fusion of joint of toe (fusion of metatarsophalangeal, interphalangeal joints or revision of fusion) T744,T748,T809,T819 T962,T963,T968,W031 W032,W033,W034,W035	**Surgical Referral for symptomatic Hallux Valgus (Bunion)** . Surgical correction for hallux valgus using minimal access techniques (IPG332) is not commissioned. Evidence on safety is inadequate therefore procedure should only be used within special arrangements for clinical governance, consent and audit or research.	Surgical referral has not been made for cosmetic purposes alone Referral for surgical consideration of hallux valgus shall only be considered where a patient meets ALL of the following: • Patients must have been triaged or seen in an Musculoskeletal Intermediate Service (MIS) or MSK Podiatrist • Patients have persistent symptoms despite at least 6 months of conservative management • Significant persistent pain preventing patients from fulfilling vital activities of daily living	**Restricted**

W036,W041,W043,W064 W065,W068,W069,W072 W081,W082,W083,W084 W085,W088,W091,W091 W093,W122,W132,W133 W134,W141,W143,W144 W151,W152,W153,W154 W155,W156,W157,W158 W159,W161,W163,W164 W209,W214,W281,W282 W283,W318,W319,W328 W431,W451,W453,W454 W551,W552,W553,W561 W562,W569,W570,W571 W572,W573,W578,W581 W591,W592,W593,W594 W595,W596,W598,W599 W601,W602,W621,W622 W628,W629,W631,W638 W639,W642,W694,W712 W712,W778,W784,W788 W789,W791,W792,W793 W798,W799,W811,W812 W815,W816,W816,W817 W818,W902,W903,W919 W923,W924,X103,X111 X112,X118,X119,X251 X382,X382,X598,X599 Y037,Y064,Y264,Y531 Y532,Y535,Y539,Y668 Y713,Y716,Y767,Y809 Y822,Y829,Z124,Z125 Z126,Z128,Z129,Z505 Z506,Z518,Z581,Z583 Z585,Z586,Z591,Z598 Z599,Z621,Z624,Z775		**OR** • Severe deformity which prevents the patient from wearing suitable footwear AND/OR Prior conservative management must include **ALL** of the following: • Reasonable modification of footwear – avoidance of high-heeled shoes, narrow fitting shoes. Wear wide fitting shoes which will naturally stretch and breathe • Non-surgical treatments • Simple analgesia	
Z791,Z792,Z793,Z794 Z795,Z798,Z799,Z801, Z802,Z803,Z804,Z808	**Common Foot and Ankle Procedures**	Treatment of and not exclusive: claw toe, hallux rigidus, hammer toe, in growing toenail, metatarsalgia, Morton's neuroma, plantar fasciitis, metatarsal damage, achilles	**Restricted**

Z809,Z853,Z854,Z855 Z856,Z858,Z859,Z861 Z864,Z865,Z866,Z868 Z869,Z872,Z905,Z906 Z907,Z924,Z941,Z942 Z943		tendon disorders, tibialis posterior dysfunction, arthritis are not routinely commissioned by the CCGs except if the following criteria are met:- Patients must have been triaged or seen in the Musculoskeletal Intermediate Service (MIS). • Have persistent symptoms despite at least 6 months of conservative management excluding in growing toe nail • Significant persistent pain preventing patients from fulfilling vital activities of daily living **OR** • Have recurrent ulcers and infections Prior conservative management must include **ALL** of the following:- • Reasonable modification of footwear – avoidance of high-heeled shoes, narrow fitting shoes. Wear wide fitting shoes which will naturally stretch and breathe • Simple analgesia • Foot/ankle exercises	
	Acquired Flat Foot Stage I Disease – Debridement, this may be supplemented with the use of an arthrodesis screw Stage II Disease - a Flexor Digitorum Longus transfer, Calcaneal Osteotomy and Spring ligament Reefing. Adjunctive procedures include gastrocnemius recession, midfoot fusion or osteotomy and subtalar arthrodesis. Stage III Disease - Triple arthrodesis of the subtalar, calcaneocuboid and talonavicular joints. Stage IV Disease - Pantalar fusion or a triple fusion and ankle replacement.	Referral for surgical consideration of flat foot shall only be considered where a patient meets ALL of the following: • MUST have been triaged or seen in a Musculoskeletal Intermediate Service (MIS) or MSK podiatric Service for assessment and orthotic provision • If the patient is unresponsive to conservative treatment or there is significant persistent pain or loss of function impacting on daily living • Surgery will be considered for patients with flatfeet (who have pre-existing or recent onset of symptomatic flat feet) in the following circumstances: • If the deformity is recent onset or deteriorating this	**Restricted**

		should be made a priority. • If the patient is unable to go up onto tip-toe unaided and standing only on the affected foot or if the foot is not correctable when assessed on the couch	
	Hind foot – Treatment for arthritis • Image guided/targeted injections can be used as a diagnostic and also therapeutic tool. • Hind foot fusions of one, two or three of the hind foot joints is a surgical procedure to relieve severe pain from arthritis or correct painful deformity. • Double and triple fusion (involving the talonavicular and calcaneocuboid joints)	Patients must have been triaged or seen in the Musculoskeletal Intermediate Service (MIS) **AND** • Exhausted appropriate non operative interventions as specified in the OA pathway • Appropriate analgesia	**Restricted**
	Symptomatic ankle arthritis: Refer to a Consultant Orthopaedic Foot & Ankle Surgeon for consideration of surgery:	Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS) **AND** • Be unresponsive to conservative treatment **AND** • Have symptomatic Osteoarthritis Phonophoresis (The use of ultrasound to enhance the delivery of topically applied drugs Prolotherapy (Injection of e.g. dextrose into tissues to try to promote healing), Platelet Rich Plasma Cryotherapy (use of cooling to promote healing)	**Restricted** **Excluded** **Excluded** **Excluded** **Excluded**

		Viscosupplementation (this has gone through clinical priority advisory group (CPAG) and scored as low evidence	
	Arthroscopy & Debridement (ankle)	Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS) **AND either/or** • Unresponsive to conservative treatment • Clinical examination or MRI scan has demonstrated clear evidence that there is an internal joint derangement e.g. removal of ankle/subtalar loose bodies, debridement of osteochondral defects and resection of scar tissue	**Restricted**
	Ankle Replacement – Arthroplasty is the responsibility of NHS England https://www.england.nhs.uk/wp-content/uploads/2013/06/d10-spec-orthopaedics.pdf	Commissioned by NHS England	**Excluded**
A70.1 Implantation of neuro-stimulator into peripheral nerve Skin surface FES: A70.7 Application of transcutaneous electrical nerve stimulator In addition a site code from chapter Z is assigned depending on the nerve into which the stimulator is implanted or applied. The ICD-10 code M21.3 Wrist or foot drop (acquired) would also be recorded	**Functional Electrical Stimulation (FES) for Foot Drop** (this is also included in the ERP)	FES using skin surface electrodes will be commissioned for patients who meet the following criteria. **This is exempt from the requirement for Musculoskeletal Intermediate Service referral as the problem is neurological in origin.** **ALL** patients must have had a successful trial of FES and demonstrate improved gait. • The patient has foot drop caused by upper level nerve damage • The patients has been assessed by a specialist in foot drop of neurological origin and all treatment options have been considered	**Restricted**

		• There is evidence that foot drop has caused trips or falls, or gait issues • The patient can walk a minimum of 10 metres independently (+/- aids) • The patient can physically manage a FES (+/- minimal assistance) • The patient's cognitive ability is such that they can manage a FES independently • The patient does not have co morbidities which would affect their capacity to benefit from FES • The patient does not have any of the known clinical contraindications to FES • Clear FES treatment goals and expectations of benefit are outlined, this is in relation to the effectiveness and these are assessed annually. outlined	
	Other types of FES (implanted or wireless) are not commissioned.	Not routinely commissioned	**Excluded**

8 Upper Limb

Shoulder pain is the third most common reason for musculoskeletal consultations in general practice, after back and neck pain. Shoulder pain accounts for 5% of all GP encounters, with a lifetime risk of 30% in the general population. In a study of adults consulting for shoulder pain in a UK primary care setting, a prevalence of 2.36% and incidence of 1.47% were reported, peaking at 50 years and showing a linear increase with age.[7]
Shoulder symptoms can cause significant distress to patients, resulting in severe socio-economic loss to society with an increased burden on the health-care budget. However medical intervention should not be undertaken in the first instance unless otherwise indicated.

8.1.1 Shoulder Procedures

OPCS Codes	Shoulder Condition/Procedure	Threshold	Status
ICD10: M750 - adhesive capsulitis 2015/16 ICD-10-CM	**Arthroscopic Capsular Release (ARC) for Adhesive Capsulitis (Frozen Shoulder)**	Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS)	**Restricted**

[7] **Linsell L, et al. 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.**

Diagnosis Code M75.01 (right shoulder) M75.02 (left shoulder) M75.00 (unspecified shoulder)		Consideration will be given for those patients who have not responded to a maximum of 3 months of conservative management as listed below:- • Appropriate medicines management • Physiotherapy (Minimum of 6 weeks, continue for a further 6 weeks if patients function and symptoms have improved) May include advice, exercises, manual therapy, thermotherapy, electrotherapy and steroid injection • Have relevant patient information leaflets/support • Patients must have significant persistent pain preventing them from fulfilling vital activities of daily living • Disturbance of sleep **AND** • Have failed to respond to a steroid injection in conjunction with physiotherapy	
	Hydrodilatation for Adhesive Capsulitis (frozen shoulder).	Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS) Consideration will be given for those patients who have not responded to maximum of 3 months of conservative management as listed below:- • Appropriate medicines management • Have relevant patient information leaflets/support • Physiotherapy • Patients must have significant persistent pain < 3months preventing them from fulfilling vital activities of daily living • Disturbance of sleep Due consideration to be given MUA & injection as valid alternative to hydrodilation	**Restricted**
	Ultrasound and/or MRI for soft tissue shoulder (if rotator cuff injury is suspected)	Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS) or be under the care of a Rheumatologist, Pain Management Consultant Consideration will be given for those patients who have not responded to 6 weeks of conservative management as listed below:- • Appropriate medicines management	**Restricted**

		• Have relevant patient information leaflets/support • Patients must have significant persistent pain preventing them from fulfilling vital activities of daily living • Disturbance of sleep	
	Diagnostic Arthroscopy	The CCGs do not support the use of arthroscopy for diagnostic purposes. Alternatives should be used such as X-ray, MRI, Ultrasound	**Excluded**
	Therapeutic Shoulder Arthroscopy	Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS) Consideration will be given for those patients who have not responded to conservative management between 3-6 months as listed below:- • Activity modification • Physiotherapy Programme • Appropriate analgesia • Steroid injections where clinically appropriate **AND** • Full thickness rotator cuff tear as demonstrated by clinical symptoms and radiological imaging **OR** • Significant superior labrum anterior posterior (SLAP) tear as demonstrated by clinical symptoms and radiological imaging **OR** • Partial thickness rotator cuff tear as demonstrated by clinical symptoms and radiological imaging which has not responded to 3 months of conservative management **OR** • Adhesive capsulitis demonstrated by clinical symptoms which has not responded to 6 months of conservative management **OR** • Adhesive capsulitis demonstrated by clinical symptoms and in the view of the treating consultant is having an extraordinarily severe impact on quality of life, and which has not responded to conservative management including	**Restricted**

		corticosteroid injection where clinically appropriate **OR** • Subcromial shoulder pain demonstrated by clinical symptoms which has not responded to 6 months of conservative management **OR** • Non-traumatic shoulder joint instability that has not responded to 6 months of conservative management **OR** • Traumatic shoulder joint instability alongside relevant conservative management as clinically appropriate	
	Therapeutic Arthroscopy for Minor (type I*) SLAP tear repair	The CCGs do not routinely fund this procedure	**Excluded**
		The CCGs do not routinely fund this procedure	**Excluded**
ICD10: S430 OPCS: W771 - repair of capsule of joint for stabilisation Z814 - shoulder joint Z94 - laterality	**Management of recurrent anterior dislocation of the shoulder. Bankart repair.** (exclude young recurrent anterior dislocation)	Patients **MUST** have been triaged or seen in Musculoskeletal Intermediate Service (MIS) if not already under a secondary care consultant. The following criteria apply:- • Young anterior dislocation (less than 25) whether first time or recurrent, should be assessed in secondary care for consideration of early stabilisation surgery (BESS guidelines). • 25-45 years can be treated by physiotherapy following initial instability, but recurrent dislocation should be seen and assessed in secondary care. • According to BESS guidelines, first time dislocation in patients over the age of 45 should be seen and assessed in secondary care to pick up cases of associated acute cuff tear. • Recurrent atraumatic structural instability in the absence of muscle patterning deemed suitable for surgical intervention https://www.rnoh.nhs.uk/sites/default/files/rehabilitation-guidelines-for-post-operative-shoulder-instability-repair-updated20june08_0.pdf	**Restricted**

	Bristow Latarjet Procedure	The CCGs do not routinely fund this procedure	**Excluded**
	Shoulder Replacement Surgery	Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS) Consideration will be given for those patients who have not responded to conservative management as listed below:- • Activity modification • Appropriate analgesia • Severe pain and functional disability that significantly interferes with activities of daily living from injury e.g. osteoarthritis, post traumatic arthritis of shoulder for at least 6 months duration **AND** • has severe limited range of motion of the glenohumeral joint on physical examination **AND** • Radiographic evidence of destructive degenerative joint disease (as evidence by 2 or more of the following: irregular joint surfaces, glenoid sclerosis, osteophyte changes, flattened glenoid, cystic changes in the humeral head, or joint space narrowing of the shoulder joint) • Elderly patients with intact but poorly functional cuff can be considered for reverse total shoulder replacement	**Restricted**
ICD10: M751 - non traumatic rotator cuff S460: traumatic injury rotator cuff OPCS: T79's - rotator cuff repair Z94 - laterality	**Reverse shoulder surgery with rotator cuff pathology**	Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS) • Appropriate analgesia • Steroid injection if clinically appropriate (injection should be no less than 3 months before referral)	**Restricted**

		• Patient information leaflets/support • Patients must have significant persistent pain preventing them from fulfilling vital activities of daily living • Disturbance of sleep • Physiotherapy programme • Lifestyle modification Surgical intervention may be considered if patient has failed to benefit from **ALL** conservative treatments and patient remains in significant pain and activities of daily living are greatly affected **AND** a total shoulder replacement has been considered **AND** there is evidence of rotator cuff dysfunction. **FOR ANY OTHER INDICATION CLINICIANS MUST APPLY FOR FUNDING VIA THE IFR DEPARTMENT.**	
O29.1, (W08.5 or 08.9 or 57.2 with Z81.2)	**Subcromial Decompression for shoulder pain**	Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS) Patient's must have undergone 6-8 weeks of conservative management:- • Appropriate analgesia • Steroid injection if clinically appropriate • Patient information leaflets/support • Patients must have significant persistent pain preventing them from fulfilling vital activities of daily living. • Disturbance of sleep. • Physiotherapy programme • Life style modification • Referral supported by appropriate imaging Surgical intervention may be considered if patient has failed to respond to **ALL** conservative treatment and patient remains in significant pain and activities of daily living are greatly affected.	**Restricted**
	Rotator Cuff Disorders	Patients **MUST** have been triaged or seen in the	**Restricted**

		Musculoskeletal Intermediate Service (MIS) and have had:- • Appropriate analgesia • Steroid injection if clinically appropriate • Patient information leaflets/support • Patients must have significant persistent pain preventing them from fulfilling vital activities of daily living. Abduction of shoulder between 60 and 120 degrees. • Disturbance of sleep. • Physiotherapy programme • Life style modification Surgical intervention may be considered if patient has failed: • Evidenced base conservative treatment and patient remains in significant pain and activities of daily living are greatly affected	
	Supra-scapula nerve block – May offer temporary benefit in reducing symptoms and facilitating engagement with physiotherapy/exercise programme	<u>Inclusion criteria:</u> • Adults with shoulder pain secondary to musculoskeletal (MSK) disorders commonly treated in MSK practice. • Osteoarthritis (GHJ or ACJ) • Adhesive capsulitis / frozen shoulder • Rotator cuff arthropathy • Single or 'one off' suprascapular nerve blocks • Either guided using radiology, or via bony landmarks <u>Exclusion criteria:</u> • Visceral pain • Cancer pain • Hemiplegic shoulder pain • Peri or post-operative pain • Continuous nerve block via indwelling catheter Patients **MUST** be referred to the Musculoskeletal Intermediate Service (MIS) and have the following:- • Persistent shoulder pain, i.e. chronic shoulder pain (more	**Restricted**

		than three month's duration) which has failed to, or only partially responded to more traditional therapies (other shoulder injections/ physio etc.) • The shoulder pain is being generated by more than one site in the shoulder e.g. AC OA with GH OA with supraspinatus cuff pathology • Nerve block should be offered conjunction with a prescribed/personalised exercise programme	

9 Spinal

9.1 Low Back pain

Low Back Pain (LBP) is extremely common and is the largest single cause of loss of disability adjusted life years, and the largest single cause of years lived with disability in England (Global Burden of Disease, 2013). In terms of disability adjusted life years lost per 100,000, LBP is responsible for 2,313. By contrast the remainder of musculoskeletal complaints counts for 911, depression 704 and diabetes 337. It should be borne in mind that this is principally occurring in people of working age, or with families.

UK specific data shows that LBP was the top cause of years lived with disability in both 1990 and 2010 – with a 12% increase over this time.
3% of the population's life is being lost to LBP.
LBP accounts for 11% of the entire disability burden from all diseases in the UK; furthermore the burden is increasing both absolutely (3.7% increase) and proportionally (7% to 8.5%).

In CG88 NICE estimated that the cost of LBP to the NHS in 2008 was £2.1 billion. The same analysis estimated that the societal cost of informal care and production loss was £10.7 billion in 1998. Overall, LBP is one of the most costly conditions for which an economic analysis has been carried out in the UK
The national pathfinder pathway project focused on low back pain and radicular in the over 16's which has led to the National Back Pain and Radicular Pain pathway published in May 2017 (3rd edition) including NICE guidance NG59. This section of the commissioning policy follows the recommendations in these.

9.1.1 Low back pain and radicular back pain procedures/treatments

OPCS Codes	Spinal Condition/Procedure	Threshold	Status
Low Back Pain	**Spinal injections**		
	X-rays and MRI of the lumbar spine for non-specific pain	MRI for Chronic lumbar back-pain (>6 weeks) with no clinical or serological indicators of infection or neoplasia or other red flags to be used in specialist care only where management will be altered.	**Restricted**
	Spinal injections – These include:	Not routinely funded for the treatment of non-specific low back pain.	**Excluded**

	• Intraarticular Facet joint injections • Intradiscal therapy • Prolotherapy • Trigger point injections		
	Alternative therapy such as acupuncture and Tens	Are not funded within the NHS	**Excluded**
	Medial nerve branch blocks as a diagnostic prior to the Radiofrequency denervation (rhizolysis)	Patients **must** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS) or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode • Patients have received a biopsychosocial assessment within a specialist pain service (ideally multidisciplinary) • Back pain severity on a scale of ≥6/10 which has been assessed using a validated pain score questionnaire such as VAS (https://www.physio-pedia.com/Visual_Analogue_Scale) • Patients must be actively involved in shared decision making in respect of their treatment and demonstrated commitment to their long term treatment plan • Patients must have a commitment in taking responsibility for managing their condition by demonstrating lifestyle changes which may include weight loss, increased fitness through exercise and physiotherapy; diet control, avoidance of illicit drugs and alcohol, and improvement in sleep patterns, managing mood and mental health; and improved engagement in activities of daily living and purposeful occupation where appropriate • Back pain has persisted for at least 12 months and all clinically appropriate conservative management options, including medication, physiotherapy and exercise, have already been tried without success • Back pain causes significant impact on daily functioning which has been assessed using the MSK HQ tool (https://www.keele.ac.uk/pchs/implementingourresearch/makinganimpact/musculoskeletalpain/msk-hghealthquestionnaire/) Radiofrequency denervation for chronic non-specific low back pain will only be funded in	**Restricted**

	Radiofrequency denervation (rhizolysis)	accordance with the criteria below: • Moderate or severe localised back pain (rated as 6 or more on a visual analogue scale or equivalent). **AND** • The main source of pain is thought to come from structures supplied by the medial branch nerve as evidenced by a previous positive response to **one** or **two** a diagnostic medial branch blocks **AND** • Patient is being treated in the context of a specialist (ideally multidisciplinary but comments above around service availability in the North also apply here) Chronic Pain Management Service • Radiofrequency denervation for chronic non-specific low back pain will only be funded in accordance with the criteria below: • Moderate or severe localised back pain (rated as 6 or more on a visual analogue scale or equivalent). **AND** • The main source of pain is thought to come from structures supplied by the medial branch nerve as evidenced by a previous positive response to **one** or **two** a diagnostic medial branch blocks **AND** • Patient is being treated in the context of a specialist (ideally multidisciplinary) Chronic Pain Management Service https://www.nice.org.uk/guidance/ng59 (See Page 55)	**Restricted**
	Spinal fusion	Spinal fusion is only commissioned for back pain in the presence of **ONE or more** of the following • Spondylolisthesis or spondylolysis • Spinal deformity • Post discectomy or decompression • Neurological compression with associate neural compression symptoms	**Excluded**
	Disc replacement	Disc replacement will not routinely be funded for patients with non-specific low back pain	**Excluded**
Lumbar Radicular Pain			
		Patients **must** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS) and exhausted all non-surgical options as appropriate during the current episode excluding Red flags	
	Diagnostic nerve root block	Diagnostic nerve root block are only funded after surgical review when decompressive surgery is being considered for nerve root compression. Repeated diagnostic nerve root blocks are not routinely funded for the same level of injection	**Restricted**

	Therapeutic nerve root block	Not routinely funded and **must** have mono-level nerve compression +/- adjacent disc pathology	**Restricted**
	Epidural injections (corticosteroid preparations e.g.) with or without anesthetic agents performed in an outpatient setting Epidural steroid injection is proven and medically necessary for the treatment of acute and sub-acute sciatica (radicular pain)	CCGs – will only fund lumbar interlaminar, transforaminal and caudal epidural injections for adult patients with radicular pain when the following criteria are met • The patient has radicular pain (below the knee for lower lumbar nerve root compromise, into the anterior thigh for upper lumbar below the knee for lower lumbar nerve root compromise) with MRI (or other appropriate imaging tests) consistent with the clinical symptoms **AND** • There is strong clinical evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise-positive between 30° and 70° or positive femoral tension sign) **AND** • Symptoms persist despite some non-operative treatment for at least 6 weeks or less for patients with very severe pain and unable to tolerate conservative management (e.g. analgesia, physical therapy, rest etc.). Patients may receive up to a maximum of 2 injections to achieve therapeutic effect within a 6 month period following the 1st injection and no further injections will be funded within that episode of care	**Restricted**
	Spinal decompression and discectomy (lumbar) for radicular pain/spinal claudication	Spinal decompression (laminectomy) and discectomy will only be funded for patients with sciatica (radicular pain) in accordance with the following criteria: Patient has been triaged or seen the Musculoskeletal Intermediate Service (MIS) and been onward referred • MRI (or similar diagnostic test) shows radicular compression with documented clinical correlation **AND** • Radicular pain (below the knee for lower nerve root compromise, into the anterior thigh for upper lumbar nerve root compromise) and neurological deficit consistent with the level of spinal involvement; **AND** • There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise-positive between 30° and 70° or positive femoral tension sign); **AND** • Symptoms persist despite non-operative treatment for at least 6 weeks (e.g. analgesia, physiotherapy, rest etc.) provided that analgesia is adequate and there is no significant neurological deficit	**Restricted**

10 References

NICE (2008, updated 2014) Osteoarthritis: care and management **https://www.nice.org.uk/guidance/cg177**

Foot and Ankle

https://www.boa.ac.uk/wp-content/uploads/2015/01/Enc-8c_Painful-deformed-great-toe-in-adults-Commissioning-guide.pdf

http://www.arthritisresearchuk.org/arthritis-information/surgery/foot-and-ankle-surgery.aspx

Royal Colleges, NICE, Cochrane UK, best practice, South East Staffordshire Clinical Prioritisation Group (CPAG).

NICE IPG278. *Functional electrical stimulation for drop foot of central neurological origin.* NICE, Jan 2009

Cambridgeshire and Peterborough Clinical Commissioning Group

Chelll, Julian, Dhar, Sunil, Pediatric hallux valgus, Foot and ankle clinics, Jun 2014, vol. 19, no. 2, p. 235-243 (June 2014)

Ferrari, J., Higgins, J.P.T. and Prior, T.D. (2004) *Interventions for treating hallux valgus (abductovalgus) and bunions (Cochrane Review) [Withdrawn].* The Cochrane Library. Issue 1. *John Wiley & Sons, Ltd*. www.thecochranelibrary.com

Ferrari, J. (2009). Bunions. BMJ clinical evidence, vol Jan 2009.

Maffulli, N. et al (2011). Hallux valgus: effectiveness and safety of minimally invasive surgery. A systematic review. British Medical Bulletin, Jan 2011, vol. 97, p. 149-167.

NICE interventional procedure guidance [IPG332] (2010) *Surgical correction of hallux valgus using minimal access techniques*

NICE Clinical Knowledge Summary (2012) Bunions

Nix, S., Smith, M. & Vicenzino, B. (2010). Prevalence of hallux valgus in the general population: a systematic review and meta-analysis. Journal of foot and ankle research, Jan 2010, vol. 3, p. 21.

Saro, C. et al. (2007) Quality-of-life outcome after hallux valgus surgery. Quality of life research : an international journal of quality of life aspects of treatment, care and rehabilitation, Jun 2007, vol. 16, no. 5, p. 731-738

Kottink AIR at al. The orthotic effect of functional electrical stimulation on improvement of walking in stroke patients with a dropped foot: a systematic review. *Artificial organs*. 2004;28(6):577-86

Esnouf JE, et al. Impact on activities of daily living using a functional electrical stimulation device to improve dropped foot in people with multiple sclerosis, measured by the Canadian Occupational Performance Measure. *Multiple Sclerosis* 2010;16(9):1141–1147

Stein RB, et al. Long-Term Therapeutic and Orthotic Effects of a Foot Drop Stimulator on Walking Performance in Progressive and Nonprogressive Neurological Disorders. *Neurorehabilitation and Neural Repair* 2010;24(2):152–167

Taylor P, et al. Economic Justification for the Odstock Dropped Foot Stimulator (ODFS). ISPO meeting 3rd Nov 2007.

Economic Report. Functional Electrical Stimulation for dropped foot of central neurological origin [Internet]. NHS Purchasing and Supply Agency. 2010 Feb. CEP10012.

Taylor P, et al. The long-term cost-effectiveness of the use of functional electrical stimulation for the correction of dropped foot due to upper motor neuron lesion. *J Rehabil Med* 2013; 45: 154–160

Morton's Neuroma South Staffordshire CPAG scored 112 in November 2015

E Clinical Knowledge Summary. Morton's neuroma. June 2010

Briggs, P.J. (2006) Morton's neuroma. British Journal of Hospital Medicine 67(2), 68-71.

Hassouna, H. and Singh, D. (2005) Morton's metatarsalgia: pathogenesis, aetiology and current management. Acta Orthopaedica Belgica 71(6), 646-655

Thomson CE, Gibson JNA, Martin D. Interventions for the treatment of Morton's neuroma. Cochrane Database of Systematic Reviews 2004, Issue 3. Art. No.: CD003118. DOI: 10.1002/14651858.CD003118.pub2

Shoulder Procedures

Manual therapy and exercise for adhesive capsulitis (Frozen shoulder) - Clinical Prioritisation Advisory Group (CPAG) joint North Staffordshire and scored 85

Page MJ, et al. manual therapy and exercise for adhesive capsulitis (frozen shoulder). Cochrane Database Syst Rev. 2014 Aug 26;8:CD011275.

Arthroscopic Capsular Release for Adhesive Capsulitis (Frozen Shoulder) – CPAG scored 92, South Staffordshire in October 2016.

[1] Van der Windt DA, Koes BW, de Jong BA and Bouter LM. Shoulder disorders in general practice: incidence, patient characteristics and management. Ann Rheum Dis

1995; 54: 959–64.

[1] Grant JA, Schroeder N, Miller BS, Carpenter JE. Comparison of manipulation and arthroscopic capsular release for adhesive capsulitis: a systematic review. Journal of Shoulder and Elbow Surgery 2013; 22(8): 1135-1145

[1] Uppal HS, Evans JP, Smith C. Frozen shoulder: A systematic review of therapeutic options. World Journal of Orthopedics. 2015;6(2):263-268. doi:10.5312/wjo.v6.i2.263.

[1] Le Lievre HM, Murrell GA. Long-term outcomes after arthroscopic capsular release for idiopathic adhesive capsulitis. J Bone Joint Surg Am. 2012 Jul 3;94(13):1208-16. doi: 10.2106/JBJS.J.00952.

[1] Austgulen OK, Øyen J, Hegna J, Solheim E. Arthroscopic capsular release in treatment of primary frozen shoulder. Tidsskr Nor Laegeforen. 2007 May 17;127(10):1356-8

[1] Trsek D, Cicak N, Zunac M, Klobucar H. Functional results and patient satisfaction after arthroscopic capsular release of idiopathic and post-traumatic stiff shoulder. Int Orthop. 2014 Jun;38(6):1205-11. doi: 10.1007/s00264-014-2283-4. Epub 2014 Jan 28

[1] Barnes CP, Lam PH, Murrell GA. Short-term outcomes after arthroscopic capsular release for adhesive capsulitis. J Shoulder Elbow Surg. 2016 Mar 8. pii: S1058-2746(16)00008-2. doi: 10.1016/j.jse.2015.12.025. [Epub ahead of print]

[1] NICE Clinical Knowledge Summary - Shoulder pain. April 2015

[1] Dattani R, Ramasamy V, Parker R, Patel VR. Improvement in quality of life after arthroscopic capsular release for contracture of the shoulder. Bone Joint J. 2013 Jul;95-B(7):942-6. doi: 10.1302/0301-620X.95B7.31197

Hydrodilation for Adhesive Capsulitis (Frozen Shoulder) – CPAG scored 87, South Staffordshire CPAG.

[1] Van der Windt DA, Koes BW, de Jong BA and Bouter LM. Shoulder disorders in general practice: incidence, patient characteristics and management. Ann Rheum Dis

1995; 54: 959–64.

[1] Buchbinder R, Green S, Youd JM, Johnston RV, Cumpston M. Arthrographic distension for adhesive capsulitis (frozen shoulder). Cochrane Database of Systematic Reviews 2008, Issue 1. Art. No.: CD007005. DOI: 10.1002/14651858.CD007005.

[1] Buchbinder R, Green S, Forbes A, Hall S, Lawler G. Arthrographic joint distension with saline and steroid improves function and reduces pain in patients with painful stiff shoulder: results of a randomised double-blind placebo-controlled trial. Annals of Rheumatic Disease 2004;63:302-9.

[1] Tveitå EK, Tariq R, Sesseng S, Juel NG, Bautz-Holter E. Hydrodilatation, corticosteroids and adhesive capsulitis: A randomized controlled trial. BMC Musculoskeletal Disorders. 2008;9:53. doi:10.1186/1471-2474-9-53.

[1] Uppal HS, Evans JP, Smith C. Frozen shoulder: A systematic review of therapeutic options. World Journal of Orthopedics. 2015;6(2):263-268. doi:10.5312/wjo.v6.i2.263.

[1] Quraishi NA, Johnston P, Bayer J, Crowe M, Chakrabarti AJ. Thawing the frozen shoulder. A randomised trial comparing manipulation under anaesthesia with hydrodilatation. J Bone Joint Surg Br. 2007;89:1197–1200.

[1] Yoon JP, Chung SW, Kim JE, Kim HS, Lee HJ, Jeong WJ, Oh KS, Lee DO, Seo A, Kim Y. Intra-articular injection, subacromial injection, and hydrodilatation for primary frozen shoulder: a randomized clinical trial. J Shoulder Elbow Surg. 2016 Mar;25(3):376-83. doi: 10.1016/j.jse.2015.11.009. [ABSTRACT]
[1] Hegmann KT, editor(s). Occupational medicine practice guidelines. Evaluation and management of common health problems and functional recovery in workers. 3rd ed. Elk Grove Village (IL): American College of Occupational and Environmental Medicine (ACOEM); 2011. p. 1-297

[1] NICE Clinical Knowledge Summary - Shoulder pain. April 2015

Ultrasound as primary investigation for soft tissue injuries – CPAG scored 85, North Staffordshire CCG in March 2016

Mitchell C, Adebajo A, Hay E, Carr A. Shoulder pain: diagnosis and management in primary care. BMJ 2005. Nov 12; 331 (7525): 1124-1128 doi: 10.1136/bmj.331.7525.1124

Urwin M, Symmons D, Allison T, Brammah T, Busby H, Roxby M, et al. Estimating the burden of musculoskeletal disorders in the community: the comparative prevalence of symptoms at different anatomical sites, and the relation to social deprivation. Ann Rheum Dis 1998;57: 649-55.

Van der Windt DAWM, Koes BW, De Jong BA, Bouter LM. Shoulder disorders in general practice: Incidence, patient characteristics, and management. Ann Rheum Dis. 1995;54(12):959–964. doi: 10.1136/ard.54.12.959

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 Feb;45(2):215-21. Epub 2005 Nov 1.

Hide G. Ultrasonography for rotator cuff injury. Medscape 2011 http://www.uhasselt.be/Documents/UHasselt/initiatieven/2012/schouderklachten/4-Medische%20beelvorming/4-A-Ultrasonography%20Rotator%20Cuff%20Injury-Medscape-2011.pdf

Dinnes J., Loveman E., McIntyre L., Waugh N. A systematic review of the effectiveness of diagnostic tests for the assessment of shoulder pain due to soft tissue disorders: a systematic review. Health Technology Assessment 2003: Vol. 7: No 29

Lenza M., Buchbinder R., Takwoingi Y., Johnston R. V., Hanchard N., Faloppa F. Magnetic resonance imaging, magnetic resonance arthrography and ultrasonography for assessing rotator cuff tears in people with shoulder pain for whom surgery is being considered. Cochrane Database of systematic reviews, 2013, Issue 9. Art No.: CD009020. DOI: 10.1002/14651858.CD009020.pub2.

Shahbpour M, Kichouch M, Laridon E, Gielen J, de Mey J. The effectiveness of diagnostic imaging methods for the assessment of soft tissue and articular disorders of the shoulder and elbow. European Journal of Radiology Volume 65, Issue 2, February 2008, Pages 194–200

The Diagnosis and Management of Soft Tissue Shoulder Injuries and Related Disorders. Accident Compensation Corporation (ACC) New Zealand, 2004.

Optimising management of rotator cuff problems. Guideline and evidence report. American Academy of Orthopaedic Surgeons 2010.

Therapeutic Shoulder Arthroscopy

Coghlan JA, Buchbinder R, Green S, Johnston RV, Bell SN, Surgery for rotator cuff disease, Cochrane Database of Systematic Reviews 2008, Issue 1. Art. No.: CD005619. DOI: 10.1002/14651858.CD005619.pub2

NICE CKS revised April 2015 accessed online via http://cks.nice.org.uk/shoulder-pain#!scenariorecommendation on 01/06/2016

Woo Hyung Lee et al, Clinical Outcomes of Conservative Treatment and Arthroscopic Repair of Rotator Cuff Tears: A Retrospective Observational Study, Ann Rehabil Med 2016;40(2):252-262 pISSN: 2234-0645 eISSN: 2234-0653 -http://dx.doi.org/10.5535/arm.2016.40.2.252

Baums et. al. Functional outcome and general health status in patients after arthroscopic release in adhesive capsulitis. Knee Surg Sports Traumatol Arthrosc. 2007 May; 15(5):638-44.

Snow M, Boutros I, Funk L. Posterior arthroscopic capsular release in frozen shoulder. Arthroscopy. 2009 Jan; 25(1):19-23.

Fernandes MR. Arthroscopic treatment of adhesive capsulitis of the shoulder with minimum follow up of six years. Acta Ortop Bras. 2015 Mar-Apr; 23(2): 85–89. doi: 10.1590/1413- 78522015230200613 PMCID: PMC4813413

Wei Dong et. al. Treatments for Shoulder Impingement Syndrome. A PRISMA Systematic Review and Network Meta-Analysis, Medicine, Volume 94, Number 10, March 2015

Longo et. al. Humeral Avulsion of the Glenohumeral Ligaments: A Systematic Review. Arthroscopy. 2016 May 12. pii: S0749-8063(16)00248-6. doi: 10.1016/j.arthro.2016.03.009.

Snyder classification (Snyder SJ, Karzel RP, Del Pizzo W, et al. SLAP lesions of the shoulder. Arthroscopy 1990; 6:274 –279)

Shoulder Surgery

[1] Singh JA, et al. Surgery for shoulder osteoarthritis. Cochrane Database Syst Rev. 2010;6(10):CD008089.

[1] National Center for Chronic Disease Prevention and Health Promotion, Division of Adult and Community Health. Arthritis. http://www.cdc.gov/arthritis/

[1] Linsell L, et al. 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.

[1] Millett PJ, et al. shoulder osteoarthritis; diagnosis and management. Am Fam Phys 2008;78(5):605-11,612

[1] Lee LH, Desai A. Reverse polarity shoulder replacement: Current concepts and review of literature. World J Orthop 2014; 5(3): 255-261 Available from: URL: http://www.wjgnet. com/2218-5836/full/v5/i3/255.htm DOI: http://dx.doi.org/10.5312/ wjo.v5.i3.255

[1] Chalmers PN & Keener JD. Expanding roles for reverse shoulder arthroplasty. Curr Rev Musculoskelet Med (2016) 9:40–48 DOI 10.1007/s12178-016-9316-0
http://www.aetna.com/cpb/medical/data/800_899/0837.html

Shoulder Surgery – Reverse Arthroplasty

https://www.evidence.nhs.uk/search?q=reverse+shoulder+replacement
Van de Sande M A, Brand R, Rozing P M. Indications, complications, and results of shoulder arthroplasty. Scand J Rheumatol. 2006;35(6):426-34.

Carter M J, Mikuls T R, Nayak S, Fehringer E V, Michaud K. Impact of total shoulder arthroplasty on generic and shoulder-specific health-related quality-of-life measures: a systematic literature review and meta-analysis. J Bone Joint Surg Am. 2012 5;94(17):e127.

Levy D M, Abrams G D, Harris J D, Bach B R, Nicholson G P and Romeo A A. Rotator cuff tears after total shoulder arthroplasty in primary osteoarthritis: A systematic review. Int J Shoulder Surg. 2016 Apr-Jun; 10(2): 78–84.

Samitier G, Alentorn-Geli E, Torrens C and Wright T W. Reverse shoulder arthroplasty. Part 1: Systematic review of clinical and functional outcomes. Int J Shoulder Surg. 2015 Jan-Mar; 9(1): 24–31.

Alentorn-Geli E, Samitier G, Torrens C, and Wright T W. Reverse shoulder arthroplasty. Part 2: Systematic review of reoperations, revisions, problems, and complications. Int J Shoulder Surg. 2015; 9(2): 60–67.

Farshad M & Gerber C. Reverse total shoulder arthroplasty - from the most to the least common complication. International Orthopaedics 2010 34:1075 - 1082.

Meislin R J, Sperling J W, Stitik T P. Persistent shoulder pain: epidemiology, pathophysiology, and diagnosis. American journal of orthopedics 2005; 34(12 Suppl(5-9), 1078-4519.

http://www.cambsphn.nhs.uk/Libraries/Surgical_Threshold_Policies/Shoulder_Replacement_Dec16_-_V1.sflb.ashx

Subacromial Decompression for Shoulder Impingement

[1] Ketola, S,Lehtinen, J,Rousi, T,Nissinen, M,Huhtala, H,Konttinen, Y T,Arnala, I. No evidence of long-term benefits of arthroscopicacromioplasty in the treatment of shoulder impingement syndrome: Five-year results of a randomised controlled trial. Bone & joint research, vol. 2, no. 7, p. 132-139, 2046-3758 (2013)

[1] NICE Clinical Knowledge Summary - Shoulder pain – April 2015

[1] Butt, U,Whiteman, A,Wilson, J,Paul, E,Roy, B. Does arthroscopic subacromial decompression improve quality of life. Annals of the Royal College of Surgeons of England, vol. 97, no. 3, p. 221-223, 1478-7083 (April 2015). [ABSTRACT]

[1] Is arthroscopic subacromial decompression effective for shoulder impingement? Journal of Family Practice 2015; 64(11).

[1] Jaeger M, Berndt T, Rühmann O, Lerch S. Patients With Impingement Syndrome With and Without Rotator Cuff Tears Do Well 20 Years After Arthroscopic Subacromial Decompression. Arthroscopy. 2016 Mar;32(3):409-15. doi: 10.1016/j.arthro.2015.08.026. Epub 2015 Oct 24.

[1] Biberthaler P, Beirer M, Kirchhoff S, Braunstein V, Wiedemann E, Kirchhoff C. Significant benefit for older patients after arthroscopic subacromial decompression: a long-term follow-up study. International Orthopaedics. 2013;37(3):457-462. doi:10.1007/s00264-012-1760-x.

[1] Konradsen, Lars Aage Glud,Jensen, Claus Hjorth. Arthroscopic subacromial decompression results in normal shoulder function after two years in less than 50% of patients. Danish medical journal, vol. 62, no. 3, 2245-1919 (March 2015)

[1] Dorrestijn O, Stevens M, Winters JC, van der Meer K, Diercks RL. Conservative or surgical treatment for subacromial impingement syndrome: a systematic review. Journal of Shoulder and Elbow Surgery 2009; 18(4): 652-660

[1] Royal College of Surgeons for England (RCSEng). Commissioning guide: Subacromial Shoulder Pain. 2014.

[1] Dong W, Goost H, Lin X-B, et al. Treatments for Shoulder Impingement Syndrome: A PRISMA Systematic Review and Network Meta-Analysis. Sahin. A, ed. Medicine. 2015;94(10):e510. doi:10.1097/MD.0000000000000510.

Rotator Cuff Injury

Oh LS, et al. Indications for rotator cuff repair: a systematic review. *Clin Orthop Relat Res* 2007;(455):52-63.

Sher JS, et al. Abnormal findings on magnetic resonance images of asymptomatic shoulders. *J Bone Joint Surg Am* 1995; 77(1):10-15.

Garg S, et al. Managing rotator cuff disorders. Reports on the Rheumatic Diseases | Series 6 | Topical Reviews No 7. Arthritis research UK, 2010

NICE. *Shoulder pain*. Clinical Knowledge Summaries. NICE, April 2015

British Elbow & Shoulder Society (BESS), British Orthopaedic Association (BOA), Royal College of Surgeons for England (RCSEng) *Subacromial shoulder pain.* Commissioning Guideline. RCS, London 2014.

Yamaguchi K, et al. Natural history of asymptomatic rotator cuff tears: a longitudinal analysis of asymptomatic tears detected sonographically. *J Shoulder Elbow Surg* 2001;10(3):199-203.

Coghlan JA, et al. Surgery for rotator cuff disease. *Cochrane Database Syst Rev.* 2008;23(1):CD005619.
Tashjian RZ. Is there evidence in favor of surgical interventions for the subacromial impingement syndrome? *Clin J Sport Med.* 2013 Sep;23(5):406-7

American Academy of Orthopaedic Surgeons Clinical Practice Guideline Optimizing the management of rotator cuff problems. AAOS, 2010

The University of New South Wales,Clinical Practice Guidelines for the Management of Rotator Cuff Syndrome in the Workplace. Sydney, 2013

Vitale MA, et al. Rotator cuff repair: an analysis of utility scores and cost-effectiveness. *J Shoulder Elbow Surg.* 2007 Mar-Apr;16(2):181-7

Ultrasound as primary investigation for soft tissue shoulder injuries when rotator cuff is suspected - Clinical Prioritisation Advisory Group (CPAG) North Staffordshire and scored 85

Mitchell C, Adebajo A, Hay E, Carr A. Shoulder pain: diagnosis and management in primary care. BMJ 2005. Nov 12; 331 (7525): 1124-1128 doi: 10.1136/bmj.331.7525.1124

Urwin M, Symmons D, Allison T, Brammah T, Busby H, Roxby M, et al. Estimating the burden of musculoskeletal disorders in the community: the comparative prevalence of symptoms at different anatomical sites, and the relation to social deprivation. Ann Rheum Dis 1998;57: 649-55.

Van der Windt DAWM, Koes BW, De Jong BA, Bouter LM. Shoulder disorders in general practice: Incidence, patient characteristics, and management. Ann Rheum Dis. 1995;54(12):959–964. doi: 10.1136/ard.54.12.959

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 Feb;45(2):215-21. Epub 2005 Nov 1

Hide G. Ultrasonography for rotator cuff injury. Medscape 2011
http://www.uhasselt.be/Documents/UHasselt/initiatieven/2012/schouderklachten/4-Medische%20beelvorming/4-A-Ultrasonography%20Rotator%20Cuff%20Injury-Medscape-2011.pdf

Dinnes J., Loveman E., McIntyre L., Waugh N. A systematic review of the effectiveness of diagnostic tests for the assessment of shoulder pain due to soft tissue disorders: a systematic review. Health Technology Assessment 2003: Vol. 7: No 29

Lenza M., Buchbinder R., Takwoingi Y., Johnston R. V., Hanchard N., Faloppa F. Magnetic resonance imaging, magnetic resonance arthrography and ultrasonography for assessing rotator cuff tears in people with shoulder pain for whom surgery is being considered. Cochrane Database of systematic reviews, 2013, Issue 9. Art No.: CD009020. DOI: 10.1002/14651858.CD009020.pub2.

Shahbpour M, Kichouch M, Laridon E, Gielen J, de Mey J. The effectiveness of diagnostic imaging methods for the assessment of soft tissue and articular disorders of the shoulder and elbow. European Journal of Radiology Volume 65, Issue 2, February 2008, Pages 194–200

Accident Compensation Corporation (ACC) New Zealand, 2004 'The Diagnosis and Management of Soft Tissue Shoulder Injuries and Related Disorders'

Optimising management of Rotator Cuff problems. Guideline and evidence report. American Academy of Orthopaedic Surgeons 2010.