Arden and Greater East Midlands
Commissioning Support Unit

NHS Birmingham and Solihull,
NHS Sandwell and West Birmingham,
NHS Dudley
NHS Walsall
NHS Wolverhampton
Clinical Commissioning Groups

Harmonised Treatment Policies – Phase 3a

'YOU SAID, WE DID' SUMMARY REPORT

November 2019

Contents

Treatment Policies Clinical Development Group.

YOU SAID – WE DID Report.

Background

In July 2018 the 5 Birmingham and Black Country CCGs (Birmingham & Solihull CCG; Sandwell & West Birmingham CCG; Dudley CCG; Walsall CCG and Wolverhampton CCG) committed to working together to review 3 orthopaedic treatment policies. The membership of the Birmingham & Solihull and Sandwell and West Birmingham Treatment Policies Clinical Development Group was extended for Phase 3a to include members from Dudley CCG; Walsall CCG and Wolverhampton CCG. Membership of the TPCDG includes clinical and management stakeholders who have met regularly in 2019 to discuss and assess the 3 Evidence Reviews and the related draft policies.

The Treatment Policies Clinical Development Group provides the required governance and oversight of the policy programme by:

- Providing direct clinical input and examination of nationally and, where appropriate, internationally available contemporary evidence research.
- Monitoring project planning, timelines and progress of all treatment policy areas.
- Initial engagement with a range of relevant stakeholders including local provider clinical subject matter experts, council members of the Birmingham and Solihull Councils' Joint Health and Oversight Committee and the Sandwell Council Health Oversight Committee, and patient and public representatives.
- Ensuring the appropriate input, endorsement and sign off of the updated policies.

Public and Clinical Engagement

A core element of the policy harmonisation programme has been the public and clinical engagement period. For a six-week period (*September 2nd – October 11th 2019*) – Birmingham & Solihull, Sandwell & West Birmingham, Dudley, Walsall and Wolverhampton Clinical Commissioning Groups undertook a joint clinical and public consultation exercise. The purpose of the engagement was both to share 3 draft policies (and accompanying literature including draft patient leaflets, Equality Impact Analyses and Evidence Reviews) and gather feedback on the proposals. Upon conclusion of the engagement period – a full summary report of the feedback was prepared and presented to the Treatment Policies Clinical Development Group (TPCDG) for their discussion and consideration. The full summary report is available upon request and will be published on the CCGs' Web Sites following Governing Body adoption in early 2020.

Using the seven commissioning principles to underpin their evaluation and consideration of the feedback – the TPCDG members assessed all the public and clinical feedback received and responded accordingly.

- CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment;
- CCG Commissioner require clear evidence of cost effectiveness before NHS resources are invested in the treatment;
- The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor;
- CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment;
- CCG Commissioners will balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community;
- CCG Commissioners will consider all relevant national standards and take into account all proper and authoritative guidance; and
- Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered.

The high-level components of these discussions for each of the policies are set out below in the form of a 'You Said -We Did' report.

All of the 3 Policies in Phase 3a received feedback from the public and clinical colleagues.

Policy for the Management of Subacromial Pain.

You Said:

Public Feedback:

1. I have not researched or specialised into this field- So difficult to have an opinion.
2. For some patients who have tried conservative treatments this may offer some relief
3. The resources could be better used
4. There are clinical instances especially in trauma where this might be beneficial in improving function, so it will have to tailored to patient needs
5. Has helped some patients
6. I feel each case must be looked at and treated on its merit
7. Don't treat this
8. There may be some people the procedure helps.
9. Not qualified to make such a judgement
10. Important to widen the scope of NHSE policy on ASD to all causes
11. I don't think it should be a blanket "no". The surgeon and GP should have the final say
12. A family member had keyhole surgery to relieve pain and restricted movement in a shoulder. Treatment very successful. Following a traumatic injury to my shoulder I was not offered treatment other than physiotherapy; the shoulder still gives pain and still has some restricted movement.
13. Need to be careful that treatment is not seen to be restricted on the criteria of age of patient
14. If it's not beneficial it shouldn't be offered.
15. Leave the decision to the patient, GP and specialist

Clinical Feedback:

16. Directorate Lead Consultant Surgeon: Thank you. I have been advised by our specialised upper limb experts. Happy with this.
17. Sometimes, that is the last resort. As a doctor, very difficult to say, sorry you suffer from pain, we will not do anything.
18. Patients report benefit and withdrawing assumes that the clinical evidence is absolutely correct - it is often not
19. Clinical lead MSK Physio. Community. Firstly, an appraisal of evidence and sense check of final commissioning decision appears sound. I.e: 'Due to the limited quality of evidence of clinical and cost effectiveness, surgery for sub-acromial pain syndrome is not routinely commissioned. This means the patient's NHS commissioning organisation (CCG), who is responsible for buying healthcare services on behalf of patients, will only fund the treatment if an Individual Funding Request (IFR) application has shown exceptional clinical need and the CCG supports this.' However, the evidence cited regarding condition aetiology omits current, non-orthopaedic trends concerning the pathophysiology of subacromial pain syndromes. This is important, as the information given under the heading 'What is Subacromial Pain in Adults?' fails to acknowledge the uncertainty that exists

in this area. Instead, the policy asserts the condition is caused thus: Shoulder impingement (pain in the top and outer side of the shoulder) occurs when the tendon rubs or catches on the acromion and the sub-acromial bursa. Pain may start suddenly or come on gradually, and may occur if the tendon is swollen, thickened or torn due to injury, overuse or age-related 'wear and tear'.
This information has been contested for a number of years, and indeed is possibly one of the reasons why the benefits of surgical arthroplasties/decompressions are not significantly better than doing nothing at all (at 12 and 24/12 F/Us).
Rotator cuff tendinopathy/shoulder impingement syndrome appear to be multi-factorial in nature & should be treated as such. Perhaps it would be wise to inform the patient thus:
"Previously it was thought that pain occurs when the top of the tendon rubs or catches on the acromion and the sub-acromial bursa, however more recent studies have shown that between 76-91% RC tears occur within the tendon or on 'under-side' of the tendon. Also, there has shown to be poor correlation between acromial shape and pain. Furthermore, RC tears can continue to develop post SAD. To this end routine SAD surgery for this condition is no longer recommended routinely". Lewis (2011, 2016)
I think that getting this background information right helps both the health practitioner (be it Consultant, GP or physiotherapist) and patient alike make better informed shared-decisions concerning treatment. Also, it doesn't on one-hand provide clarity (i.e. this is how your condition is caused), whilst with the other withdraw care (i.e. 'but we no longer fund surgery for this'), as this is likely to cause frustration and high numbers of IFRs (individual funding requests).

20. Rheumatology Consultant - Thank you for passing this on. My comments below apply to surgical decompression and to hydro-dilatation. The conclusions of these reviews is expected from recent reviews and trials. My concern is that there will be a significant number of patients with intractable and difficult shoulder pain who will need surgical or radiologic intervention. This is likely to involve more than a handful of patients. To require an individual funding request for each of these is problematic and frustrating for all concerned. I think it would have been useful to have an algorithm that made clear when funding would be likely if patients had failed to respond to standard approaches. As it stands this policy does not acknowledge the real difficulty some patients will have. The current policy does not provide a comprehensive pathway for these patients.
21. GPSI I have had many of my patients undergo this procedure especially with tears of the rotator cuff. I feel that this procedure does have a place if conservative measures fail.
22. Consultant Shoulder Surgeon: yes, in agreement with these. I was part of the CSAW (Can Shoulder Arthroscopy Work?) which showed that SAD is not an effective treatment. This also reflects my practice where for many years now I have not been offering SAD to my patients. I still perform SAD though as part of other procedures e.g. during repair of a full thickness rotator cuff tear etc. I refer impingement patients to physio and also consider steroid injection

23. Consultant Surgeon: Re the subacromial pain – This is a highly controversial topic, with the quoted studies also being contested in terms of methodology and interpretation of results. Let's not throw the baby out with the bath water! Not all patients with shoulder pain, have impingement. It is a vastly over diagnosed (wrongly) condition in any case, as a result of which other causes of shoulder pain can be missed. So, if patients are not referred at all based on the assumption that they have impingement, we will only end up seeing these patients very much later with their condition having become more complex and in need of more invasive, expensive treatment (cuff tears are an example). I would also point out that impingement is not a diagnosis made by imaging alone. No scan in itself can confirm a diagnosis of impingement, it needs other tests also; and most importantly an interpretation of the scan findings in conjunction with clinical findings. Therefore, in my view we may find fewer patients having surgery initially, but we might be storing up bigger problems for later on. A more sensible approach would be to have strict criteria (as for other conditions like Dupuytrens or CTS) that need to be met before surgery is offered. I should add that we as a group of shoulder surgeons have already seen a big reduction in the number of arthroscopic subacromial decompressions being performed, simply through a tighter patient selection process based on the results of the studies quoted. We do not like to operate on patients who are not likely to get a good result from surgery either!
24. Consultant Surgeon: Your list of operations / eligibility criterion does not include chronic cuff tears as an indication for surgery. Recently concluded UKUFF trial has shown the procedure to be clinically and cost effective. There is good evidence to show that cuff tears progress in size and then the concern is they may become irreparable over time. Large irreparable tear is one of the most difficult clinical problems to deal with in younger age. So chronic cuff tear repair surely has to be part of the indications. Subacromial decompression is more often done as an associated procedure, alongside other procedures. Patients may be listed for subacromial decompression + other procedure (for e.g. cuff repair, removal of calcium deposits). If the tear was reported inaccurately on scan and was noted to be too small to repair, or was much bigger than anticipated, patient may end up having an isolated subacromial decompression surgery (despite not being planned for it). These scenarios have to be considered. Isolated subacromial decompression for impingement pain is not a common procedure anyway. However, there are odd indications, just like with other limited clinical value procedures. I am not sure the intention of this document was to address this issue, or the whole list of shoulder operations.

We Did:

Public Feedback

1.; 3.; 7; 9.; 10; 14.

The CCGs welcomed the public feedback, the development of clinical policies is based on review of the most up to date clinical evidence.

2.; 5; 6; 8; 11; 15.

The CCGs welcomed the public feedback, the development of clinical policies is based on review of the most up to date clinical evidence. The evidence shows this surgical intervention does not improve the patient's symptoms any more than

physiotherapy and conservative treatments and so the CCGs cannot support surgical intervention when there are no greater benefits for the patients compared to conservative treatment.

4. The policy ensures that any patients who has 'red flag' symptoms with acute shoulder pain, e.g. dislocated shoulder, their care will be determined by an acute care pathway and fall outside of the remit of this policy.
12. Each patient's symptoms will be assessed on an individual basis by a specialist clinician, to ensure that the treatment is tailored to that individual patient. There are some injuries, where symptoms cannot be fully cured despite evidence-based management and management of on-going symptoms will be part of the care package for the patient. The evidence shows this surgical intervention does not improve the patient's symptoms any more than physiotherapy and conservative treatments and so the CCGs cannot support surgical intervention when there are no greater benefits for the patients compared to conservative treatment.
13. This policy for Subacromial Pain does not have any age restrictions attached.

Clinical Feedback

16. The CCGs welcomed the clinical feedback and would like to thank the specialist team for reviewing the clinical policy and for their support in implementing the policy.
17. The CCGs would not want a doctor to say to a patient 'sorry you are in pain we will do nothing'. The CCGs have reviewed the most up to date clinical evidence to determine the most clinically effective treatment for patients with subacromial pain. The treatment pathway the doctor should be offering the patient, should be conservative management, e.g. physiotherapy; pain management etc. The evidence review determined the lack of clinical effectiveness of the surgical intervention over conservative treatment and therefore the CCGs cannot support a surgical intervention which the evidence demonstrates would have no greater benefit to the patient but carries the ensuing risks of surgery.
18. There are varying levels of clinical evidence, the CCGs asked NHS Solutions for Public Health to undertake a rigorous review of the most up to date clinical evidence so they may review the level of evidence available in regard to this surgical intervention. The grade of evidence reviewed was to a high standard. The CCGs want to ensure the best use of the NHS resources available to them and so want to ensure that interventions available to patients are clinically effective above conservative measures, which in Subacromial Pain, the efficacy of surgery has not been demonstrated in the clinical evidence above that of conservative management.
19. The CCGs welcomed the clinical feedback and would like to thank the specialist for reviewing the clinical policy and for their support in implementing the policy. The clinical information provided has been reviewed by the policy development committee and incorporated into the revised policy.
20.; 21; 22. The CCGs welcomed the clinical feedback and would like to thank the specialist for reviewing the clinical policy, the committee discussed at length the issues raised, but the standard of evidence presented in the evidence review was extremely high, to demonstrate that surgical intervention does not have greater benefit for the patient over conservative measures and no further

evidence was submitted to the committee for review which provided evidence of clinical circumstances in which the surgical intervention could be beneficial.

23. The CCGs welcomed the clinical feedback and would like to thank the specialist for reviewing the clinical policy, the committee discussed at length the issues raised, but the standard of evidence presented in the evidence review was extremely high, to demonstrate that surgical intervention does not have greater benefit for the patient over conservative measures and no further evidence was submitted to the committee for review which provided evidence of clinical circumstances in which the surgical intervention could be beneficial. The policy would not stop the patient being referred to a specialist for diagnosis of the cause of the subacromial pain and the committee would encourage GPs to refer patients where a diagnosis is unclear in line with Right Care and GIRFT principles.

24. The purpose of the policy document was to review the surgical intervention of arthroscopic shoulder decompression surgery in any clinical circumstances as an isolated surgical intervention or as an adjunct to another surgical intervention. The clinical evidence does not support the use of arthroscopic shoulder decompression surgery in any clinical circumstances. Other shoulder surgery interventions are not part of this clinical policy and have not been considered in the evidence review only ASD as a stand alone or as an adjunct procedure are covered by this policy.

Policy Outcome

- **The draft policy is endorsed by the TPCDG and will proceed to the next stage of CCG governance for sign off and implementation.**

Policy for the use of Image Guided Therapeutic Intra-Articular Joint Injections.

You Said:

Public Feedback:

1. I have not researched or specialised into this field- So difficult to have an opinion...
2. It can only be better than what I am suffering now
3. will make patients unhappy
4. Some people tolerate pain better than others, so it comes back to the individual doctor and patient.
5. Don't treat this
6. Better use of clinicians time
7. The patient will be happy
8. If a patient has been having this service and it is changed he or she will think this is just a cost cutting exercise
9. If a patient knows that only treatment that is proven to work is offered, surely they will have more confidence.
10. It will affect patient presenting elsewhere asking for solutions only to be told that you must see GP. No intervention is going to be successful until all clinicians (A/E, walk in centre) all say the same language.
11. Breakdown in doctor-patient relationship

Clinical Feedback:

12. It is very difficult to administer an injection into the hip especially if the anatomy is also altered and hence safer and also beneficial to inject under imaging guidance. Hence, I would support injections under guidance for hips for this reason. knee joint injections can be done without imaging due to the ease of access. I do not undertake any injections in the ankle or foot to be able to comment.
13. Hip injections are difficult to perform without image guidance and for small joints such as hands and wrists it is vital to be sure the injection is in the right place
14. Hip joint injection is difficult to give without guidance as wrong place can be injected.
15. Rheumatology Consultant: We, in rheumatology, do perform standard steroid injections without imaging in outpatient settings but the guidance does not cover steroid injections under imaging to hip, subtalar and sacroiliac joints where it is practically difficult to inject without imaging.
16. GPSI: I have injected joints for forty years always on feel alone. I have had a ultrasound machine and now do some injections ultrasound guided like injected Planter Fascia Parthenon, Gluteal Tendinopathy, Ankle Joint, Biceps Tendon etc. I feel that ultrasound has a place in small joints and some tendinopathies. In my service I do not apply any additional premium and charge the same whether the injection is blind or US guided. Viscosupplement Injections I believe that there is a small role in some

patients like patients with Arthritis of the knee Grade I or II and Glenohumeral joint osteoarthritis. I have used this injection and we charge the same as for a normal joint injection. The difference is that the preparation (Ostenil) needs three procedures (injections) at weekly intervals.

17. OTS Clinical Lead: I have read and agree with the comments from all of my colleagues within Secondary Care and have nothing to add.

    Summary:

    •Large Osteoarthritic joints do not require US-guided injections (exception: Hip joint)

    •Small joints (e.g. in the hand and foot) where accuracy is important would benefit from US-guidance

18. Alternative service model: 3 roomed department with a trained specialist nurse, MSK sonographer and Consultant Rheumatologist with special interest in ultrasound. The department sees approximately 40-50 patients per week for diagnostic scans and provides a similar sized service for ultrasound guided injections and aspirations.

19. Rheumatology Consultant: On behalf of rheumatology I am pleased to feedback. The draft that applies to us is the policy on image guided therapeutic intra-articular injections. I would reassure you that already we would only offer an image-guided injection if a patient has failed to respond to conventional pharmacological and non-pharmacological treatment. My comments are:

    a. This policy only discusses injections in relation to osteoarthritis. Therefore, this policy needs to be explicit for OA i.e. the title must be:
    b. “Policy for the use of Image Guided Therapeutic Intra-Articular Joint Injections in Osteoarthritis”
    c. There is also a small group of patients you have failed to consider, where it is clinically unsafe to inject an (OA) joint without imaging guidance eg the hip. The actual hip joint (not the trochanteric bursa) can only be injected under imaging guidance as it is too deep for a ‘blind’ injection, and there is a large neurovascular bundle that must be avoided. Injecting the actual hip joint must remain an exclusion to this policy.
    d. There are some joints in the foot/ankle e.g. subtalar, midfoot joints where due to the complex anatomy it is impossible to palpate the joint line ‘blindly’, making ‘blind’ injections impossible. Patients here would therefore require imaging guidance for injections, and this must remain an exclusion to the policy.
    e. This policy only refers to joints. Infiltration around tendons requires imaging guidance due to the risk of ‘blind’ injections causing tendon rupture. Infiltrating around tendons must remain an exclusion to this policy.

f. More detail is required as to the evidence which needs to be presented in order to show successful outcome (what outcome measure tools do you require) and how many do you define as adequate, in image guided injections of the small joints?

20. GP: My only comment is on the USS guided injections (as my partner in practice is hoping to develop a community based service- conflict of interest here) is that I think the policy should be that “where possible- these USS guided injections of small joints should be offered in the community by primary care”. This will hopefully facilitate a shift from mainly secondary care based work more into primary and support the efforts of the MCP.

21. I've gone over the draft and appreciate there is an agenda which has obviously bias the interpretation of evidence. On a purely factual basis, there are some issues with reference duplication which I'm sure will be picked up on - citation 4, 5 and 6 are also 12, 13 and 15.

    Page 5, Para 2, 2nd sentence is incorrect as the evidence states that USGI results in better pain and functional status at 6 months.
    Page 5, Para 3, I'm not sure how many DRUJ injections you do but it should be very small and cannot be translated into knee, shoulder, or other joints and represents poor scientific application of evidence.
    Citation 1 is purely a scoping document and has no additional information to Citation 2 which says exactly the same thing regarding the quote so should be removed.
    Citation 2 does not separate USGI (ultrasound-guided injection) and LMGI (landmark-guided injection).
    Citation 3 is regarding the use of hyaluronate suggesting that it is as effective as a steroid which I doubt for a second the CCG would want us to use.
    Citation 4 states USGI is better than LMGI.
    Citation 5 states there is no real benefit of steroid injections at all.
    Citation 6 says USGI is more accurate but doesn't conclude the clinical outcome is any different.
    Citation 7 says USGI gives maximum benefit.
    Citation 14 says USGI is better at 6 months.
    Citation 16 says USGI is better tolerated, more effective at 6 months and more cost-effective.
    Citation 17 says USGI of the knee is no better than LMGI.
    Citation 18 is not cited and has no relevance to the document.
    Citation 19 is not cited and states steroid only has limited benefit in the knee and less for hip and hand.
    Evidence that has not been included but should be:

    a. USGI are more clinical + cost-effective - https://bjgp.org/content/67/661/378
    b. USGI shoulder injections significantly greater clinical improvement over LMGI - https://www.ncbi.nlm.nih.gov/pubmed/26590864
    c. USGI Carpal Tunnel Syndrome better for several markers - https://bjgp.org/content/67/661/378

d. USGI shoulder significant improvement in pain and abduction vs LMGI but small and suggests further research - https://www.ncbi.nlm.nih.gov/pubmed/23275390
e. USGI improves efficiency and cost-effectiveness but more research is needed - https://www.ncbi.nlm.nih.gov/pubmed/29511701

We Did:

Public Feedback

1.-11. The CCGs welcomed the public feedback, the development of clinical policies is based on review of the most up to date clinical evidence. The clinical evidence demonstrates that the use of image guidance in performing therapeutic injections does not provide a better outcome for the patient with regard to pain relief therefor the patient will be able to access palpated joint injections via their clinical team to gain the same injections as currently are offered.

Clinical Feedback.

12.-17. The CCGs welcomed the clinical feedback and would like to thank the clinician for reviewing the clinical policy and for their support in implementing the policy. As stated in the policy eligibility criteria, the policy relates to joint injections only and joint injections into the spine, hip joint and small joints of the hands and feet are outside of the remit of this policy as the clinical evidence demonstrated greater efficacy of these injections when image-guidance is used.

18.&19. The CCGs welcomed the clinical feedback and would like to thank the clinician for reviewing the clinical policy and for their support in implementing the policy. The feedback regarding clarity of diagnosis was discussed by the policy committee and the policy revised to include all patients with arthritis. As stated in the policy eligibility criteria, the policy relates to joint injections only, not diagnostic scans and not injections into the tendons. Joint injections into the spine, hip joint and small joints of the hands and feet are outside of the remit of this policy as the clinical evidence demonstrated greater efficacy of these injections when image-guidance is used.

20. The CCGs welcomed the clinical feedback and would like to thank the clinician for reviewing the clinical policy and for their support in implementing the policy. It would be by the committee that all primary care treatment options are exhausted before a referral to primary care is made, however unless there is clinical evidence to demonstrate the need for a patient to be reviewed by a specific team, in line with the committee's commitment to offer choice to patients, a specific referral pathway cannot be mandated within the policy.

21. The CCGs welcomed the clinical feedback and would like to thank the clinician for reviewing the clinical policy. The feedback on the clinical evidence was reviewed by the committee and taken into account when reviewing the final policy document. In response to the submitted evidence, this was again reviewed by the committee and the following findings were made:

a. & c. William Wynter Bee and James Thing, 2017. Ultrasound-guided injections in primary care: evidence, costs, and suggestions for change. British Journal of General Practice 2017; 67 (661): 378-379.
DOI: https://doi.org/10.3399/bjgp17X692117
Submitting clinician assertion: USGI are more clinical + cost-effective

Committee Review: The Paper reviews the use of ultrasound guided injections in carpal tunnel and aims to review if U/S guidance can be done more cost effectively in primary care saving on a secondary care referral. In ascertaining that Ultrasound guided injections are more effective than palpated injection, the paper relies on a consensus statement from the American Medical Society for Sports Medicine, where the cohort of patients to be treated under this policy will largely be those affected by arthritis and not a sports injury and a study by Huang et al 2015. Effectiveness of Ultrasound Guidance on Intraarticualr and Periarticular Joint Injections: Systematic Review and Meta-Analysis of randomized Trials. Am J Phys Med Rehabilitation. 2015 Oct;94(10):775-83. doi: 10.1097/PHM.0000000000000260., which found the following conclusion: Intraarticular and periarticular injections using ultrasound guidance significantly improves the accuracy of joint injections, and there is a significant decrease in visual analog scale scores for up to 6 weeks after injection. The effect of ultrasound guidance on the long-term outcome of joint injections is inconclusive. The inconclusive findings in regard to the long-term outcomes of ultra-sound guided injections and the breadth of evidence the committee had already reviewed in developing the policy, this Systematic Review was insufficient evidence to change the policy criteria.

b. Wu T[1], Song HX[2], Dong Y[2], Li JH. 2015. Ultrasound-guided versus blind subacromial-subdeltoid bursa injection in adults with shoulder pain: A systematic review and meta-analysis. Semin Arthritis Rheum. 2015 Dec;45(3):374-8. doi: 10.1016/j.semarthrit.2015.05.011. Epub 2015 May 21. https://www.ncbi.nlm.nih.gov/pubmed/26590864
Submitting clinician's conclusion: USGI shoulder injections significantly greater clinical improvement over LMGI
Committee Review: The author's conclusion within the paper is as follows: Ultrasound-guided corticosteroid injections potentially offer a significantly greater clinical improvement over blind SASD bursitis injections in adults with shoulder pain. The committee reviewed the paper as per the author's conclusion, found that there is a potential, but not a confirmed significantly greater clinical improvement demonstrated by the findings of the paper as per the author's conclusions and therefore the paper did not outweigh the evidence already reviewed by the committee in developing the policy.

d. Sage W[1], Pickup L, Smith TO, Denton ER, Toms AP. 2013 The clinical and functional outcomes of ultrasound-guided vs landmark-guided injections for adults with shoulder pathology--a systematic review and meta-analysis. Rheumatology (Oxford). 2013 Apr;52(4):743-51. doi: 10.1093/rheumatology/kes302. Epub 2012 Dec 28.
Submitting clinician's conclusion: USGI shoulder significant improvement in pain and abduction vs LMGI but small and suggests further research
Committee Review: The author's conclusions in the paper are as follows: There is a statistically significant difference in pain and abduction between LMG and USG steroid injections for adults with shoulder pathology. However, these differences are small and may not represent clinically useful differences. The current evidence base is limited by a number of important methodological weaknesses, which should be considered when interpreting these findings. The cost-effectiveness of the intervention should be considered in the design of

future studies. The committee would agree with this conclusion that whilst there is some statistical significance, these are small and cannot be used in this evidence review to demonstrate clinically useful differences.

e. Daniels EW[1], Cole D[1], Jacobs B[2], Phillips SF[1]. 2018 Existing Evidence on Ultrasound-Guided Injections in Sports Medicine. Orthop J Sports Med. 2018 Feb 22;6(2):2325967118756576. doi: 10.1177/2325967118756576. eCollection 2018 Feb. https://www.ncbi.nlm.nih.gov/pubmed/29511701
Submitting clinician's conclusion: USGI improves efficiency and cost-effectiveness but more research is needed

Committee Review: Again the committee noted that this paper is specifically for sports medicine as opposed to the majority of patients within the cohort of patients requiring joint injections, i.e. patients with arthritis. The committee also noted the author's conclusion: 'While current studies indicate that ultrasound guidance improves efficacy and cost-effectiveness of many injections, these studies are limited and more research is needed'. The committee accepted that there is some evidence to support the use of image guidance in some joint injections, e.g. hip injections, the studies to support use of image guidance in all joint injections are insufficient to outweigh the weight of evidence already reviewed by the committee in demonstrating that image guided therapeutic injections do not provide clinically significant superior outcomes to palpated therapeutic joint injections.

Policy Outcome

- **The draft policy was revised to include all patients with arthritis and is endorsed by the TPCDG and will proceed to the next stage of CCG governance for sign off and implementation.**

Policy for the use of Image Guided High Volume Intra-Articular Injections

You Said:
Public Feedback:

1. On the understanding that non-guided injections of large joints will still be made available to patients where this treatment offers pain relief when conservative methods have failed
2. Do not fully understand
3. Only as last resort
4. Should be done first
5. If the practitioner is experienced in this field I would have thought the decision on treatment would be down to him
6. I think it is dangerous to insert a injection into large joints without image guidance
7. This depends on each individual patient
8. Clear evidence
9. I have had guided and unguided injections and I think it is the skill of the surgeon that can determine the effectiveness of this treatment
10. Important that if this treatment is restricted that GPs and other clinicians are well trained and practised in the delivery of articular large joint injections, which can gift relief to many patients.
11. I believe the person delivering image guidance would be more qualified, my husband has had injections given wrongly which has caused more pain and he has needed even more injections to put it right. Would a more careful service of imagery have saved pain time and money.
12. Non effective treatment is no treatment and should not be offered.
13. Leave the decision to the patient, GP and specialist

Clinical Feedback:

14. Consultant: Happy with this
15. Consultant: I have reviewed the treatment policy of image guided high volume Intra articular injections, and agree with it.
16. GPSI: High Volume Injections
    a. I feel that there is a role for HVI especially in Achilles Tendinopathy again we perform these at no additional premium to our tariffs.

    Hydro-dilatation in Adhesive Capsulitis
    This has a role in Adhesive Capsulitis it can stretch the tissues and make it easier to move the joint. Most patients don't need it if treated appropriately in early stages(Freezing stage)
    The success rate is over 70% for shoulder movement and 90% for improving pain. It is a non-surgical procedure.

The alternative is Arthroscopy(Arthrolysis).
We Did: 1.-13. The CCGs welcomed the public feedback, the development of clinical policies is based on review of the most up to date clinical evidence. The clinical evidence demonstrates that the use of image guidance in performing high volume injections does not provide a better outcome for the patient than conservative offered and may cause damage to the patient's joint. Therefore, the high volume injections whether image guided or palpated will not be funded by the CCG. As in the earlier policy, palpated therapeutic injections (small volume of steroid) will still be available to patients if clinically appropriate. 14. & 15. The CCGs welcomed the clinical feedback and would like to thank the clinician for reviewing the clinical policy and for their support in implementing the policy. 16. The policy under consideration relates to high volume joint injections, not to injections into tendons. The committee reviewed the evidence surrounding hydrodilation in adhesive capsulitis as set out in the evidence review which accompanied the draft policy during the engagement phase. The conclusion in the evidence review stated: The systematic review (with meta-analysis) by Saltychev et al (2018) reported that hydrodilatation with corticosteroids has only a small, clinically insignificant effect for pain and ROM (seven RCTs) when treating adhesive capsulitis. Conversely, Catapano et al (2018) reported that the intervention is likely to be effective. However, this conclusion was based on the results from two of five RCTs and three of five RCTs which reported improvements in pain scores and range of movement respectively. The evidence is therefore at best inconsistent. No long term results were reported. Both authors report that the included RCTs were of moderate quality. Therefore, without further submission of supporting evidence to demonstrate the following statistics: 'The success rate is over 70% for shoulder movement and 90% for improving pain. It is a non-surgical procedure.' The policy development committee again reviewed the clinical evidence set out in the evidence review and concluded that there was insufficient clinical evidence to support the use of high volume injections in adhesive capsulitis.
Policy Outcome • **The draft policy is endorsed by the TPCDG and will proceed to the next stage of CCG governance for sign off and implementation.**