**PRIOR APPROVAL REQUEST**

**Adult Shoulder Arthroscopy**

Hertfordshire and west Essex Evidence Based Intervention policies can be viewed at <https://www.hweclinicalguidance.nhs.uk/clinical-policies>

Academy of Medical Royal College’s EBI policy

<https://www.aomrc.org.uk/ebi/clinicians/arthroscopic-shoulder-decompression-for-subacromial-pain/>   
  
with the local supplement at  
<https://www.hweclinicalguidance.nhs.uk/clinical-policies>

Shoulder arthroscopy for diagnostic purposes alone is not funded.

**Please complete and return this form along with clinic letter/supporting evidence to:**

For west Essex patients [priorapproval.hweicb@nhs.net](mailto:priorapproval.hweicb@nhs.net) Tel: 01992 566150

For Hertfordshire patients [priorapproval.hweicb@nhs.net](mailto:priorapproval.hweicb@nhs.net) Tel: 01707 685354

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| **Patient consent** | This application has been discussed with the patient and the patient consents to relevant information being shared with the ICB | Please tick |

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| **Date form completed** |  |
| **Urgency** | Routine (5 working days turnaround time)  Urgent (2 working days turnaround time)  **Note: An urgent request is one in which a delay may put the patient’s life at risk.**  **Turnaround times commence the working day after receipt of the funding application** |
| **Patient details**  **Complete all fields or use patient sticker** | Name: Date of birth: - - / - - / - - - -  Address:  Telephone number: NHS No:  Hospital No:  GP Name: Practice: |
| **Applying Clinician’s details** | Consultant Name: Hospital/Organisation:  Contact details:  (Including email) |
| **Declaration** | I declare that the information provided is, to the best of my knowledge, true and I am aware that this procedure may be subject to clinical audit. |
| **Please specify laterality** | Left or Right  (When bilateral surgery is required, each site must be applied for separately) |

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| **Diagnosis** | **Tick** | **Action** |
| Labral tears |  | Complete box 1 |
| Rotator cuff repair |  | Complete box 1 |
| Adhesive capsulitis |  | Complete box 1 |
| Non-traumatic joint instability |  | Complete box 1 |
| Sub-acromial decompression for pure subacromial shoulder impingement |  | Complete box 2 (if not pure, prior approval is not required) |
| Frozen shoulder/adhesive capsulitis post fractures |  | Routinely funded proceed to treat |

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| **Criteria box 1** | **Tick** |
| Please include evidence that conservative management has included one or more of the following treatments  Activity modification  Oral analgesics, including NSAIDs (unless contraindicated)  Physiotherapy and exercise programme  Steroid injections to the affected part of the joint where clinically appropriate  **AND one of the following** |  |
| Full thickness rotator cuff tear as demonstrated by clinical symptoms and radiological imaging. |  |
| Significant superior labrum anterior posterior (SLAP) tear as demonstrated by clinical symptoms and radiological imaging. |  |
| Partial thickness rotator cuff tear as demonstrated by clinical symptoms and radiological imaging which has not responded to 3 months of conservative management. |  |
| Minor (type I) SLAP tear as demonstrated by clinical symptoms and radiological imaging which has not responded to 3 months of conservative management. |  |
| Adhesive capsulitis demonstrated by clinical symptoms which has not responded to 6 months of conservative management. |  |
| 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 corticosteroid injection where clinically appropriate. |  |
| Non-traumatic shoulder joint instability that has not responded to 6 months of conservative management. |  |
| Traumatic shoulder joint instability alongside relevant conservative management as clinically appropriate. |  |

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| **Criteria box 2**  **For subacromial decompression for pure subacromial shoulder impingement ALL the following must apply** | **Tick** |
| Pure subacromial impingement is not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain or calcific tendinopathy AND |  |
| Non-operative treatment such as physiotherapy/exercise programmes have been undertaken and found to be ineffective in resolving the shoulder pain AND |  |
| There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. |  |

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| **For patients where the criteria are not met and it can be demonstrated that there is an exceptional healthcare need, an Exceptional Case Request Form can be submitted to the IFR team.** |

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| **Shared decision making** | Patients should be supported with their decisions. Resources that can support implementation of shared decision making can be found on the NHS England website:  <https://www.england.nhs.uk/shared-decision-making/guidance-and-resources/> |

**HWE ICB Fitness for Elective Surgery policy criteria**

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| **Smoking status** | Never smoked  Current smoker  Ex-smoker – date last smoked: - - / - - / - -  For patients who currently smoke or have stopped smoking less than 8 weeks ago, please tick to show that you have made your patient aware that they will need to have stopped smoking or switched to e-cigarettes for at least 8 weeks prior to surgery |
| **Measurements** | Height: ……….cm Weight: …………kg BMI ……….. kg/m²    **BMI >40 –** Patientsare expected to reduce their weight by 15% or BMI <40 (whichever is greater).  **BMI 30-40 -** Patients are expected to lose 10% of their weight or reduce BMI to <30.  For surgery other than hip, knee or spinal, where the patient’s BMI is 30 to 40 and metabolic syndrome has been actively excluded in the last 18 months, please attach copy of evidence from GP or Community referral form.  If the patient has already achieved their target weight loss in the last 9 months, please give details of previous recorded measurements and the date recorded by clinician or, attach referral coversheet from GP or community provider.  Previous Weight: ………..kg Previous BMI ………… kg/m²  Date measured - - / - - / - - - - % weight reduction = ………….  At 9 months, if the patient has not met their target weight and/or stopped smoking, they should be reassessed for their need for- and fitness for- surgery.  See the Fitness for Elective Surgery policy at  <https://www.hweclinicalguidance.nhs.uk/clinical-policies/fitness-for-surgery/> |