NHS
Somerset
Clinical Commissioning Group

TRIGGER FINGER (INCLUDING THUMB) CRITERIA BASED ACCESS (CBA) POLICY

Version:	2021.v2
Recommendation by:	Somerset CCG Clinical Commissioning Policy Forum (CCPF)
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Name of Originator/Author:	EBI Team
Approved by Responsible Committee/Individual:	Somerset CCG Clinical Executive Group (CEC)
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Target audience:	**SCCG**: • NHS Providers • GP Practices • Contracts Team **Medical Directors:** • Somerset Foundation Trust • Yeovil District Hospital NHS FT • Royal United Hospitals Bath NHS FT
Application Form	EBI Generic application form if appropriate to apply

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CONTENTS

VERSION CONTROL

Document Status:	Current policy
Version:	2021.v2

DOCUMENT CHANGE HISTORY		
Version	**Date**	**Comments**
1516.v1a	June 2017	Changed from CSU to SCCG policy template & amended wording to General Principles
1617 v1b	December 2018	New statutory guidance for evidence based policies following the National Consultation
1819.v2	June 2020	Update template, rebranding from IFR to EBI, policy name to include 'thumb', include FCPs, fixed flexion amend to locked in any position

Equality Impact Assessment (EIA) Form OR EIA Screening Form completed. Date:	1617.v1
Quality Impact Assessment QIA. Date:	
Sponsoring Director:	Sandra Corry
Document Reference:	2021.v2

1 GENERAL PRINCIPLES (CBA)

1.1 Treatment should only be given in line with these general principles. Where patients are unable to meet these principles, in addition to the specific treatment criteria set out in this policy, funding approval may be sought from the CCG's Evidence Based Interventions Service (EBI) by submission of an EBI application form

1.2 Clinicians should assess their patients against the criteria within this policy prior to a referral and/or treatment

1.3 Treatment should only be undertaken where the criteria have been met and there is evidence that the treatment requested is effective and the patient has the potential to benefit from the proposed treatment. Where the patient has previously been provided with the treatment with limited or diminishing benefit, it is unlikely that they will qualify for further treatment

1.4 Referring patients to secondary care without them meeting the criteria or funding approval not secured not only incurs significant costs in out-patient appointments for patients that may not qualify for surgery, but inappropriately raises the patient's expectation of treatment

1.5 On limited occasions, the CCG may approve funding for an assessment only in order to confirm or obtain evidence demonstrating whether a patient meets the criteria for funding. In such cases, patients should be made aware that the assessment does not mean that they will be provided with surgery and surgery will only be provided where it can be demonstrated that the patients meets the criteria to access treatment in this policy

1.6 Patients should be advised being referred does not confirm that they will receive treatment or surgery for a condition as a consent discussion will need to be undertaken with a clinician prior to treatment

1.7 The policy does not apply to patients with suspected malignancy who should continue to be referred under 2 week wait pathway rules for assessment and testing as appropriate

1.8 Patients with an elevated BMI of 30 or more may experience more post-surgical complications including post-surgical wound infection so should be encouraged to lose weight further prior to seeking surgery. https://www.sciencedirect.com/science/article/pii/S1198743X15007193 (Thelwall, 2015)

1.9 Patients who are smokers should be referred to smoking cessation services in order to reduce the risk of surgery and improve healing

2 POLICY CRITERIA BASED ACCESS

Mild cases of trigger finger/thumb which cause no loss of function require no treatment or avoidance of activities which precipitate triggering and may

resolve spontaneously

2.1 GPs and FCPs establish patient compliance to the criteria, with the compliance being confirmed in the Orthopaedic Assessment Services

2.2 Insulin dependent diabetic patients do not follow the injection pathway

2.3 Conservative methods of treatment should always be pursued in the first instance;

- Exercise/massage
- Rest from aggravating activities
- NSAIDs
- Splinting for 3-12 weeks

3 All patients referred on to a surgical provider must have confirmation of compliance with criteria as below from the Orthopaedic Assessment Services (OASIS) otherwise the CCG are not liable for payment;

a. Trialled unsuccessfully the conservative methods of treatment and this is clearly detailed in the referral

b. Failed to respond to at least one corticosteroid injection **OR**

c. The finger/thumb is permanently locked in the palm, that cannot be corrected by conservative measures **OR**

d. Where corticosteroid injection is contraindicated per treatment episode
    - A maximum 2 injections per trigger finger/thumb per treatment episode **OR**

e. The patient has previously had 2 other trigger finger/thumb unsuccessfully treated with appropriate non-operative methods & fulfils the above criteria **OR**

f. Diabetic

4 Trigger finger in the thumb if clinically appropriate refer to secondary care

3 BACKGROUND

3.1 Trigger finger/thumb often resolves over time and is often a nuisance rather than a serious problem. If treatment is necessary steroid injection can be considered. Surgery should only be offered in specific cases according to NICE accredited guidelines by the British Society for Surgery to the Hand, where alternative measures have not been successful and persistent or recurrent triggering, or a locked finger/thumb occurs

3.2 Trigger digit occurs when the tendons which bend the thumb/finger into the palm intermittently jam in the tight tunnel (flexor sheath) through which they

run. It may occur in one or several fingers or thumb and causes the finger/thumb to “lock” in the palm of the hand. Mild triggering is a nuisance and causes infrequent locking episodes. Other cases cause pain and loss and unreliability of hand function. Mild cases require no treatment and may resolve spontaneously

3.3 Symptoms of trigger finger/thumb can include pain at the base of the affected finger/thumb when you move it or press on it, and stiffness or clicking when you move the affected finger or thumb, particularly first thing in the morning. If the condition gets worse, your finger/thumb may get stuck in a bent position and then suddenly pop straight. Eventually, it may not fully bend or straighten

3.4 All primary care trigger finger/thumb referrals must be referred for an initial assessment, and where appropriate conservative management, to commissioned intermediate Orthopaedic Assessment services. Orthopaedic Assessment services will assess a patient’s suitability for surgery including: reference to this policy, manage patients conservatively when possible and where appropriate refer patients to secondary care for further management of their condition

http://www.sompar.nhs.uk/what-we-do/general-health/orthopaedic-assessment/

3.5 For patients who do not qualify for a referral to secondary care or do not wish to be assessed by musculoskeletal services, individual funding approval must be secured by primary care prior to referring patients seeking advice and/or corrective surgery in secondary care. Referring patients to secondary care without funding approval having been secured not only incurs significant costs in out-patient appointments for patients that may not qualify for surgery, but inappropriately raises the patient’s expectation of treatment

4 EVIDENCE BASED INTERVENTIONS PANEL APPLICATION PROCESS

4.1 Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or Consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy

4.2 Completion of a **Generic EBI Application Form** by a GP or Consultant may be put forward

4.3 Applications cannot be considered from patients personally

4.4 It is expected that clinicians will have ensured that the patient, on behalf of who they are forwarding the application for, is appropriately informed about the existing policies prior to an application to the EBIP. This will reassure the Panel that the patient has a reasonable expectation of the outcome of the application and its context

4.5 EBI applications are reviewed and considered for clinical exceptionality

For further information on 'clinical exceptionality' please refer to the NHS England IFR policy https://www.england.nhs.uk/wp-content/uploads/2017/11/comm-policy-indivdual-funding-requests.pdf

4.6 An application put forward for consideration must demonstrated some unusual or unique clinical factor about the patient that suggests they are exceptional as defined below:

- Significantly different to the general population of patients with the condition in question
- Likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition

5 ACCESS TO POLICY

5.1 If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Patient Advice and Liaison Service on Telephone number: 08000 851067

5.2 **Or write to us**: NHS Somerset Clinical Commissioning Group, Freepost RRKL-XKSC-ACSG, Yeovil, Somerset, BA22 8HR or **Email** us: somccg.pals@nhs.net

6 REFERENCES

The following sources have been considered when drafting this policy:

6.1 https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/

6.2 https://www.evidence.nhs.uk/Search?q =TRIGGER+FINGER

6.3 http://www.bssh.ac.uk/patients/conditions/18/trigger_fingert thumb

6.4 http://www.nhs.uk/Conditions/Trigger-finger/Pages/Theprocedure.aspx

6.5 https://www.nhs.uk/conditions/trigger-finger/treatment/

6.6 Amirfeyz R, McNinch R, Watts A, Rodrigues J, Davis TRC, Glassey N, Bullock J. Evidence-based management of adult trigger digits. J Hand Surg Eur Vol. 2017 Jun;42(5):473-480. doi: 10.1177/1753193416682917. Epub 2016 Dec 21

6.7 British Society for Surgery of the Hand Evidence for Surgical Treatment (BEST) http://www.bssh.ac.uk/_userfiles/pages/files/professionals/BEST%20Guidelines/BEST%20trigger%20finger%20PUBLISHED(1).pdf

6.8 Chang CJ, Chang SP, Kao LT, Tai TW, Jou IM. A meta-analysis of corticosteroid injection for trigger digits among patients with diabetes. Orthopaedics. 2018, 41: e8-e14

6.9 Everding NG, Bishop GB, Belyea CM, Soong MC. Risk factors for complications of open trigger finger release. Hand (N Y). 2015, 10: 297-300

6.10 Fiorini HJ, Tamaoki MJ, Lenza M, Gomes Dos Santos JB, Faloppa F, Belloti JC. Surgery for trigger finger. Cochrane Database Syst Rev. 2018 Feb 20;2:CD009860. doi: 10.1002/14651858.CD009860.pub2. Review

6.11 Hansen RL, Sondergaard M, Lange J. Open Surgery Versus Ultrasound-Guided Corticosteroid Injection for Trigger Finger: A Randomized Controlled Trial With 1-Year Follow-up. J Hand Surg Am. 2017;42(5):359-66

6.12 Lunsford D, Valdes K, Hengy S. Conservative management of trigger finger: A systematic review. J Hand Ther. 2017

6.13 Peters-Veluthamaningal C, Winters JC, Groenier KH, Jong BM. Corticosteroid injections effective for trigger finger in adults in general practice: a double-blinded randomised placebo controlled trial. Ann Rheum Dis. 2008 Sep;67(9):1262-6. Epub 2008 Jan 7

2.7 **Procedure and Diagnostic Codes NHS England National Policy**

when der.Spell_Dominant_Procedure in
('T692+HAND','T691+HAND','T698+HAND','T699+HAND','T701+HAND','T702+HAND','T718+HAND','T719+HAND','T723+HAND','T728+HAND','T729+HAND','Z894+HAND','Z895+HAND','Z896+HAND','Z897+HAND') and
(APCS.Age_At_Start_of_Spell_SUS between 18 and 120) and
der.Spell_Primary_Diagnosis like '%M653%' then 'P_trigger_fing'