NHS
Dudley
Clinical Commissioning Group

Equality Analysis Form

Image Guided
Intra-Articular Injections
Dudley

Project Name:	Image Guided Intra-Articular Injections
EA Author:	David King
Team:	Equality and Diversity Team
Date completed:	
Version:	1

What is the aim of the project/proposal?

Osteoarthritis (OA) refers to a clinical syndrome of joint pain accompanied by varying degrees of functional limitation and reduced quality of life. It is the most common form of arthritis, and one of the leading causes of pain and disability worldwide. It is a chronic musculoskeletal disorder characterised by involvement of all joint structures including the synovial membrane, cartilage and bone. People with osteoarthritis often have joint pain, reduced mobility, reduced participation in daily activities and poor quality of life [1].

The joints most commonly affected by OA are the knees, hips and small joints of the hand, although most joints can be affected. Pain, reduced function and effects on a person's ability to carry out their day-to-day activities can be important consequences of osteoarthritis. Pain in itself is also a complex biopsychosocial issue, related in part to a person's expectations and self-efficacy (that is, their belief in their ability to complete tasks and reach goals), and is associated with changes in mood, sleep and coping abilities. There is often a poor link between changes visible on an X-ray and symptoms of osteoarthritis: minimal changes can be associated with a lot of pain, or modest structural changes to joints can occur with minimal accompanying symptoms [2].

Contrary to popular belief, OA is not just caused by ageing and does not necessarily deteriorate. It is believed that a variety of traumas may trigger the need for a joint to repair itself which may result in a structurally altered but symptom-free joint. However, in some people, because of either overwhelming trauma or compromised repair, the process cannot fully compensate, resulting in eventual presentation with symptomatic osteoarthritis; this might be thought of as 'joint failure'. This in part explains the extreme variability in clinical presentation and outcome that can be observed between people, and also at different joints in the same person [2].

Treatment options

A range of lifestyle, pharmacological, non-pharmacological, surgical and rehabilitation interventions are effective for controlling symptoms and improving function (NICE 2012). Conventional therapies include the use of simple analgesics, non-steroidal anti-inflammatory drugs, physical therapy and intra-articular (IA) corticosteroid administration [3].

NICE published Clinical Guideline (CG177) - Osteoarthritis: care and management in February 2014 [2]. The guidelines made the following recommendations regarding intra-articular injections;

- Intra-articular corticosteroid injections should be considered as an adjunct to core treatments for the relief of moderate to severe pain in people with osteoarthritis.
- Do not offer intra-articular hyaluronan injections for the management of osteoarthritis.

Intra-articular injections of corticosteroids have been used for several decades in the management of inflammatory and degenerative joint conditions including OA when first line conservative therapies fail to provide adequate symptom relief [4].

Although osteoarthritis is generally thought to be of degenerative rather than inflammatory origin, there is evidence that an inflammatory component may be present in at least some phases of the disease. Corticosteroids are known as potent anti-inflammatory agents that act through a variety of mechanisms [5].

Traditionally, intra-articular injections have been performed using anatomical landmarks to identify the correct trajectory for needle placement. However, different anatomical-guided injection techniques have yielded inconsistent intra-articular needle positioning due, in large part, to the fact that the physician cannot directly visualize the area of interest, and variations in anatomy are common. Incorrect needle placement has been partially associated with variable clinical outcomes.

Furthermore, inaccurate corticosteroid injections may result in complications such as post-injection pain, crystal synovitis, haemarthrosis, joint sepsis, necrosis, and steroid articular cartilage atrophy, as well as systemic effects, including fluid retention or exacerbation of hypertension or diabetes mellitus. Therefore, identification of methods and proper training to aid in correct needle placement during these procedures is warranted [4, 6].

The purpose of guidance during corticosteroid joint injections is to allow visualisation, normally of the joint line typically in real time, so that the operator can achieve a more accurate and potentially safer and more effective injection [4, 5].

Research/Publications

1. National Institute for Health and Clinical Excellence (NICE). Final Scope Osteoarthritis: the care and management of osteoarthritis. London, UK :NICE; 2012 https://www.nice.org.uk/guidance/cg177/documents/osteoarthritis-update-final-scope2
    a. Last accessed 27 September 2018

2. National Institute for Health and Clinical Excellence (NICE). Osteoarthritis: the care and management of osteoarthritis. Clinical Guideline 177. London, UK: NICE; 2014

3. Griesser MJ, Harris JD et al. Adhesive capsulitis of the shoulder: a systematic review of the effectiveness of intra-articular corticosteroid injections. J Bone Joint Surg Am 2011; 93: 1727-1733.

4. Berkoff DJ, Miller LE, Block JE. Clinical utility of ultrasound guidance for intra-articular knee injections: a review. Clin Interv Aging. 2012; 7:89-95.

5. Jüni P, Hari R et al. Intra-articular corticosteroid for knee osteoarthritis. Cochrane Database of Systematic Reviews 2015, Issue 10. Art. No.: CD005328

6. Nam SH, Kim J et al. Palpation versus ultrasound guided corticosteroid injections and short-term effect in the distal radioulnar joint disorder: A randomized, prospective single-blinded study. Clin Rheumatol 2013; 12:1807-1814.

7. Arthritis Research UK, Osteoarthritis in General Practice. 2013.

8. Wluka A, Lombard C, and Cicuttini F. Tackling obesity in knee osteoarthritis. Nature Reviews Rheumatology 2013; 9(4): 225-235.

9. Kearns K, Dee A et al. Chronic disease burden associated with overweight and obesity in Ireland: the effects of a small BMI reduction at population level. BMC Public Health 2014; 14(143)

10. Clemence P, Nguyen C et al. Risk factors and burden of osteoarthritis. Annals of Physical and Rehabilitation Medicine 2016 59 (3): 134–138.

11. Spector T and MacGregor A. Risk factors for osteoarthritis: genetics. Osteoarthritis and Cartilage 2004; 12: 39-44.

12. Berkoff DJ, Miller LE, Block JE. Clinical utility of ultrasound guidance for intra-articular knee injections: a review. Clin Interv Aging. 2012; 7:89-95

13. Jüni P, Hari R et al. Intra-articular corticosteroid for knee osteoarthritis. Cochrane Database of Systematic Reviews 2015, Issue 10. Art. No.: CD005328

14. Park KD, Kim TK et al. Palpation versus ultrasound-guided acromioclavicular joint intra-articular corticosteroid injections: a retrospective comparative clinical study. Pain Physician. 2015;18(4):333–341

15. Nam SH, Kim J et al. Palpation versus ultrasound guided corticosteroid injections and short-term effect in the distal radioulnar joint disorder: A randomized, prospective single-blinded study. Clin Rheumatol 2013; 12:1807-1814.

16. Sibbitt WL Jr, Band PA et al. A randomized controlled trial evaluating the costeffectiveness of sonographic guidance for intra-articular injection of the osteoarthritic knee. J Clin Rheumatol. 2011; 17(8):409–415.

17. Fraenkel L. Ultrasound (US)-Guided Versus Sham Ultrasound Corticosteroid (CS) Knee Injections. https://clinicaltrials.gov/ct2/show/NCT01032720

18. John Hopkins University. "Blind" vs. Fluoroscopy-Guided Steroid Injections for Knee Osteoarthritis. https://clinicaltrials.gov/ct2/show/NCT02104726

19. National Collaborating Centre for Chronic Conditions (UK). Osteoarthritis: National clinical guideline for care and management in adults. London: Royal College of Physicians (UK), 2008

20. Neogi T. The epidemiology and impact of pain in osteoarthritis. Osteoarthritis Cartilage 2013; 21: 1145-1153.

Who will be affected by this work? E.g. staff, patients, service users, partner organisations etc.

Patients who would wish to access this approach**.**

Eligibility Criteria

Therapeutic image guided intra-articular corticosteroid injections are **Restricted**.

Therapeutic image guided intra-articular corticosteroid injections should be offered ONLY to patients who have failed to respond to conventional pharmacological and non-pharmacological interventions due to the limited quality of evidence of the clinical and cost effectiveness of this intervention.

AND

Therapeutic image guided intra-articular corticosteroid injections should only be undertaken in the small joints (defined as joint of the hands & feet) by a suitably qualified clinician with experience in undertaking injections into the small joints and has maintained clinical practice by undertaking an adequate number of interventions with evidence which demonstrates successful outcome of symptom control and improved function.

Pharmacological and non-pharmalogical interventions are defined as:

- Analgesics/nonsteroidal anti-inflammatory drugs (NSAIDs)
- Domestic exercise programme
- Supervised physiotherapy/manual therapy
- Non-image guided (palpated) steroid injections

N.B. Diagnostic image –guided injections are not within the remit of this policy.

This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Activity data:

Number of Procedures	Dudley

Is a full Equality Analysis required for this project?					
Yes	X	Proceed to the full Equality Analysis form (Next Page)	**No**		Explain why further analysis is not required

Reason why further analysis is not required

If a full assessment is required please ensure that the final version is approved by Neill Bucktin, Director of Commissioning – See Section 9.

EQUALITY ANALYSIS FORM (FULL)

Equality Analysis Form
If at an initial stage further information is needed to complete a section this should be recorded and updated in subsequent versions of the EA. An Equality Analysis is a developing document, if you need further information for any section then this should be recorded in the relevant section in the form and dated.

2. Evidence Used
What evidence have you identified and considered in determining the impact of this decision e.g. census demographics, service activity data, consultation responses
Latest clinical research to ensure the services being commissioned continue to be safe and clinically effective to patients. The restriction of this policy will have limited impact on those who would wish to receive the treatments, this must be balanced against the need to adhere to NICE guidelines and the clinical effectiveness evidence. The opportunity for any exceptional cases to be considered via IFR remains and will ensure treatment is available in an exceptional case.
2. Impact of decision
In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.
2.1 Age
Describe age-related impact and evidence. This can include safeguarding, consent and welfare issues.
Age range data is not available for the profile of patients requesting the procedure. Some link may be identified between older patients and increased instances of joint pain, particularly in relation to Osteoarthritis. As the treatment has been restricted, those who meet the criteria will be able to access treatment, who are the group who are deemed to benefit most. It is expected that patients not eligible would receive more suitable alternative treatment.
2.2 Disability
Describe disability-related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/learning disabilities, cognitive impairments.

As with age, pain is itself a life limiting condition and is commonly found as a co morbidity with other conditions. It has not been shown the restricting this treatment will impact on this group negatively since those who would benefit can access it.

2.3 Gender reassignment (including transgender)
Describe any impact and evidence in relation to transgender people. This can include issues such as privacy of data and harassment.
No impact identified
2.4 Marriage and civil partnership
Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part time working and caring responsibilities.
No impact identified
2.5 Pregnancy and maternity
Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part time working and caring responsibilities.
No impact identified on the basis of available data
2.6 Race
Describe race-related impact and evidence. This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures and language barriers.
No impact identified
2.7 Religion or belief
Describe any impact and evidence in relation to religion, belief or no belief on service delivery or patient experience. This can include dietary needs, consent and end of life issues.
No impact identified
2.8 Sex
Describe any impact and evidence in relation to men and women. This could include access to services and employment.

No impact identified
2.9 Sexual orientation
Describe any impact and evidence in relation to heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.
No impact identified
2.10 Carers
Describe any impact and evidence in relation to part-time working, shift-patterns, general caring responsibilities. (Not a legal requirement but a CCG priority and best practice)
No impact identified
2.11 Other disadvantaged groups
Describe any impact and evidence in relation to groups experiencing disadvantage and barriers to access and outcomes. This can include socio-economic status, resident status (migrants, asylum seekers), homeless people, looked after children, single parent households, victims of domestic abuse, victims of drug/alcohol abuse. This list is not finite. This supports the CCG in meeting its legal duties to identify and reduce health inequalities.
No impact identified
3. Human Rights
The principles are Fairness, Respect, Equality, Dignity and Autonomy.

Will the proposal impact on human rights?	No	The decision has been made in line with clinical recommendation and NICE guidance.
Are any actions required to ensure patients' or staff human rights are protected?	**No**	The patient will have the opportunity to be involved in discussions, decisions and impacts about their own healthcare with their GP and has the option for an IFR request to be made.

If so what actions are needed? *Please explain below.*

4. How will you measure how the proposal impacts health inequalities? The CCG has a legal duty to identify and reduce health inequalities

e.g. patients with a learning disability were accessing cancer screening in substantially smaller numbers than other patients. By revising the pathway the CCG is able to show increased take up from this group, this a positive impact on this health inequality.

This condition is not linked to any identified health inequality.

5. Engagement/consultation

What engagement is planned or has already been done to support this project?

Engagement activity	**With who? E.g. protected characteristic/group/community**	**Date**

Please summarise below the key finding / feedback from your engagement activity and how this will shape the policy/service decisions e.g. patient told us, so we will… (If a supporting document is available, please provide it or a link to the document)

As part of the process further targeted engagement is planned in with representative groups from among Dudley patients. In addition, it has been identified that patient and clinician information is key in ensuring that the harmonised treatment policies review delivers effective outcomes.

Patient information briefing sheets on each procedure will be developed to give more information on the procedure, eligibility criteria and signposting to further information sources, such as NHS Choices.

The initial drafts of the patient leaflets will be reviewed by a reader panel before the drafts are used as part of the six week engagement process to help people understand the complex treatments described in the policies. This will allow meaningful engagement to enable patients, members of the public and stakeholders to feedback their views on the proposed policy changes.

Once the engagement process has been completed and final decisions have been made on any proposed policy changes, the patient leaflets will then be used to help facilitate discussions between GPs and patients who are to access such services. Leaflets on the agreed policies will be uploaded onto the GP systems for access during such discussions.

Due regard will be given to both the accessible information standard and the potential need to translate such leaflets into relevant local languages.

6. Mitigations and changes
If you have identified mitigations or changes, summarise them below. E.g. restricting prescribing over the counter medication. It was identified that some patient groups require high volumes of regular prescribing of paracetamol, this needs to remain under medical supervision for patient safety, therefore an exception is provided for this group which has resolved the issue.
None required

7. Is further work required to complete this EA?			
Please state below what work is required and to what section e.g. additional consultation or engagement is required to fully understand the impact on a particular protected group (e.g. disability)			
Work needed	**Sections**	**When**	**Date completed**
e.g. Further engagement with disabled service users to identify key concerns around using the service.	*2 - Disability*	*June - July 2017*	*Sep-17*
Engagement / Consultation: Findings and results of engagement to be added	5	December 2019	

8. Development of the Equality Analysis		
If the EA has been updated from a previous version please summarise the changes made and the rationale for the change, e.g. Additional information may have been received – examples can include consultation feedback, service Activity data		
e.g. Version .01	*The impact on wheelchair users identified additional blue badge spaces are required on site to improve access for this group.*	26-Sep-17

9. Final sign off	
Completed EA forms must be signed off by the Director of Commissioning. They will be reviewed as part of the decision making process. Completed forms should be sent to: neill.bucktin@nhs.net so that the CCG can maintain an up to date log of all EAs.	
Version Approved:	