NHS
Dudley
Clinical Commissioning Group

Equality Analysis Form

Image Guided High Volume Intra-Articular Injections Dudley

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

What is the aim of the project/proposal?

Joint Pain

Pain in the joints affects millions of people worldwide. The causes of joint pain are numerous. Joint pain can be related to osteoarthritis or inflammatory joint disorders such as rheumatoid arthritis and psoriatic arthritis. Joint pain can also be as a result of traumatic injury, joint surgery or crystal deposition in the joints such as gout or chondrocalcinosisf. Other causes of joint pain include sports injuries, general sprains and strains, frozen or unstable shoulder, and bleeding into joint spaces caused by torn ligaments.

Depending on the individual, pain might be felt in the joint or in the muscles around the joint. Depending on the cause the pain may be diffuse and constant, occurring at rest or while moving. Despite the wide range of underlying conditions and symptoms, joint pain of different aetiology may share similar mechanisms, manifestations, and potential treatments.

Image Guided High Volume Intra-Articular Injections

Treatment of joint pain consists of both pharmacologic and non-pharmacologic modalities. First-line therapy generally includes analgesia and physiotherapy. If these fail, intraarticular steroid injection may be considered.

Hydrodilatation (HD) also known as arthrographic capsular distension or distension arthrography is a procedure where a high volume injection of saline solution and/or steroids or air is given into the joint usually into the glenohumeral (shoulder) joint. HD is generally carried out with a mixture of contrast medium, long acting anaesthetics, steroids, saline or air. However, because of the inherent compressibility of air, the procedure is more difficult than when saline is used. Dependent upon the contracted state of the joint capsule, HD usually occurs with an injection of between 10ml and 55ml of normal saline.

The procedure is performed under imaging guidance, using fluoroscopy, ultrasound or Computed Tomography (CT). HD is felt to provide benefit via two mechanisms: manual stretching of the capsule and thus disruption of adhesions that might be limiting the movements of the glenohumeral joint and causing pain and disability which are characteristic of adhesive capsulitis; and the introduction of cortisone, which provides a potent anti-inflammatory effect and thus prevents further recurrence of adhesion. The risk of complications is thought to be low.

Clinical Evidence Review

From the evidence reviewed, there is no clear benefit of treatment for joint pain with an image-guided high volume intraarticular injection.

Evidence from two systematic reviews of Randomised Controlled Trials (RCTS) comparing hydrodilatation with corticosteroids, and corticosteroid injection only, is conflicting. 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 Range Of Movement (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.

Evidence from one small RCT suggests that arthrographic capsular release is associated with a higher Oxford Shoulder Score (OSS) than hydrodilatation at six months follow-up. It is not known for how long this effect is likely to be sustained (Gallacher 2018). In addition, the study may not have been sufficiently powered to show any meaningful differences. The pain scores were reported by the patients who were not blinded to their treatment, this could have introduced bias. It is also unclear whether the ROM assessors were blinded to the treatments.

Guidance

1. International Association for the Study of Pain (IASP). Treating people with joint pain. Global year against pain in the joint 2016; Fact sheet no 1. International Association for the Study of Pain

2. NHS Choices [online] https://www.nhs.uk/conditions/joint-pain/ Last accessed 15 October 2018

3. Gallacher S, Beazley JC et al. A randomized controlled trial of arthroscopic capsular release versus hydrodilatation in the treatment of primary frozen shoulder. Journal of Shoulder & Elbow Surgery. 2018 Aug; 27(8):1401-6.

4. Neogi T. Joint pain epidemiology. Global year against pain in the joint 2016; Fact sheet no 11. Neogi T Joint Pain epidemiology Last accessed October 2018

5. Duncan R, Francis RM et al. Prevalence of arthritis and joint pain in the oldest old: findings from the Newcastle 85+ Study. Age and Aging 2011; 40(6):752-5.

6. Georgiannos D, Markopoulos G et al. Adhesive Capsulitis of the Shoulder. Is there Consensus Regarding the Treatment? A Comprehensive Review. The open orthopaedics journal. [Review]. 2017; 11:65-76.

7. Buchbinder R, Green S et al. Arthrographic distension for adhesive capsulitis (frozen shoulder). Cochrane Database of Systematic Reviews 2008, Issue 1. Art. No.:

CD007005.

8. Saltychev M, Laimi K et al. Effectiveness of Hydrodilatation in Adhesive Capsulitis of Shoulder: A Systematic Review and Meta-Analysis. Scandinavian Journal of Surgery: SJS. 2018:1457496918772367.

9. Catapano M, Mittal N et al. Hydrodilatation with Corticosteroid for the Treatment of Adhesive Capsulitis: A Systematic Review. Pm & R. [Review]. 2018; 10(6):623-35.

10. Maund E, Craig D et al. Management of frozen shoulder: a systematic review and cost-effectiveness analysis. Health Technology Assessment (Winchester, England).

[Research Support, Non-U.S. Gov't Review]. 2012; 16(11):1-264.

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

Eligibility Criteria:

Due to the limited quality of evidence of clinical and cost effectiveness for image-guided high volume intra-articular injections compared to alternative treatment options, this intervention is Not Routinely Commissioned.

This means 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.

Number of procedures undertaken overall and by CCG

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 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 not been shown to demonstrate significant benefits the impact on this group will be more around a perception of not being able to access a treatment. It is expected that patients 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 condition will impact on this group negatively.

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.
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 impact 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 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:	