Equality Analysis

(Health Inequalities, Human Rights, Social Value)

Image Guided High Volume Intra-Articular Injections

Before completing this equality analysis it is recommended that you:

- ✓ Contact your equality and diversity lead for advice and support
- ✓ Take time to read the accompanying policy and guidance document on how to complete an equality analysis

NHS Birmingham and Solihull Clinical Commissioning Group
NHS Sandwell and West Birmingham Clinical Commissioning Group

1. Background

EA Title	Image Guided High Volume Intra-Articular Injections		
EA Author	David King	**Team**	Equality and Diversity
Date Started	13/08/2019	**Date Completed**	
EA Version	3	**Reviewed by E&D**	

What are the intended outcomes of this work? Include outline of objectives and function aims

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.

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

	BSOL	Sandwell

2. Research

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.

Research/Publications	Working Groups	Clinical Experts
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. https://s3.amazonaws.com/rdcmsiasp/ files/production/public/Content/ContentFolders/GlobalYearAgainstPain2/2016/FactSheets/English/1.%20Patients%20and%20Joint%20Pain.pdf Last accessed 15 October 2018 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. https://s3.amazonaws.com/rdcmsiasp/files/production/public/Content/ContentFolders/GlobalYearAgainstPain2/2016/FactSheets/English/11.%20Joint%20Pain%20Epidemiology.pdf Last accessed 15 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.		

3. Impact and Evidence:

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should also include any identified health inequalities which exist in relation to this work.

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.

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.

Gender reassignment (including transgender): Describe any impact and evidence on transgender people. This can include issues such as privacy of data and harassment:

3. Impact and Evidence:
No impact identified
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
Pregnancy and maternity: Describe any impact and evidence on pregnancy and maternity. This can include working arrangements, part-time working, and caring responsibilities: No impact identified on the basis of available data.
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
Religion or belief: Describe any religion, belief or no belief impact and evidence. This can include dietary needs, consent and end of life issues: No impact identified
Sex: Describe any impact and evidence on men and women. This could include access to services and employment: No impact identified
Sexual orientation: Describe any impact and evidence on 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
Carers: Describe any impact and evidence on part-time working, shift-patterns, general caring responsibilities: No impact identified
Other disadvantaged groups: Describe any impact and evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include lower socio-economic status, resident status (migrants, asylum seekers), homeless,

3. Impact and Evidence:
looked after children, single parent households, victims of domestic abuse, victims of drugs / alcohol abuse: (This list is not exhaustive) No impact identified

4. Health Inequalities	Yes/No	Evidence
Could health inequalities be created or persist by the proposals?	No	This condition is not linked to any identified health inequality
Is there any impact for groups or communities living in particular geographical areas?	No	No impact identified
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	No	No impact identified
How will you ensure the proposals reduce health inequalities? This condition is not linked to any identified health inequality.		

5. FREDA Principles/ Human Rights	Question	Response
Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	Yes, this decision has been made in line with clinical recommendation
Respect – right to have private and family life respected	How will the person's right to respect for private and family life, confidentiality and consent be upheld?	No evidence of impact for this policy
Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	No discrimination identified
	How will this affect a person's right to freedom of thought, conscience and religion?	N/A
Dignity – the right not to be treated in a degrading way	How will you ensure that individuals are not being treated in an inhuman or degrading way?	Policy will be applied with due regard to this consideration.
Autonomy – right to respect for private & family life; being able to make	How will individuals have the opportunity to be involved in	An individual can discuss the impact with their GP

informed decisions and choices	discussions and decisions about their own healthcare?	and has the option for an IFR request to be made
Right to **Life**	Will or could it affect someone's right to life? How?	No evidence of impact for this policy
Right to **Liberty**	Will or could someone be deprived of their liberty? How?	No evidence of impact for this policy

6. Social Value

Consider how you might use the opportunity to improve health and reduce health inequalities and so achieve wider public benefits, through action on the social determinants of health.

Marmot Policy Objective	**What actions are you able to build into the procurement activity and/or contract to achieve wider public benefits?**
Enable all people to have control over their lives and maximise their capabilities	None
Create fair employment and good work for all	None
Create and develop health and sustainable places and communities	None
Strengthen the role and impact of ill-health prevention	None

7. Engagement, Involvement and Consultation

If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:

Engagement Activity	**Protected Characteristic/ Group/ Community**	**Date**

For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g. patient told us …. So we will …..):

As part of the process further targeted engagement is planned with representative groups from among Birmingham and Solihull 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. To this end an 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. These information sheets are also designed to help facilitate discussions between GPs and patients. Information briefing sheets have already been tested and uploaded onto the GP systems for the first 45 harmonised treatment policies for Birmingham and Solihull. Due regard will be given to both the accessible information standard and the potential need to translate such leaflets into relevant local languages.

8. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work:

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.

9. Mitigations and Changes :

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the **recommendations** and any **changes** to the proposal arising from the equality analysis.

None required

10. Contract Monitoring and Key Performance Indicators

Detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract (refer to NHS Standard Contract SC12 and 13):

This policy is not linked to a contract however, prospective providers remain bound by their contracts with the CCG.

11. Procurement

Detail the key equality, health inequalities, human rights, and social value criteria that will be included as part of the procurement activity (to evaluate the providers ability to deliver the service in line with these areas):

N/A

12. Publication

How will you share the findings of the Equality Analysis?

This can include: reports into committee or Governing Body, feedback to stakeholders including patients and the public, publication on the web pages. All Equality Analysis should be recommended for publication unless they are deemed to contain sensitive information.

Publication on the CCG's website.

Following approval all finalised Equality Analysis should be sent to the Communications and Engagement team for publication: bsol.comms@nhs.net

13. Sign Off

The Equality Analysis will need to go through a process of **quality assurance** by the Senior Manager for Equality and Diversity, Senior Manager for Assurance and Compliance or Equality and Human Rights Manager **and** signed-off by a delegated committee

	Name	Date
Quality Assured By:		
Which Committee will be considering the findings and signing off the EA?		
Minute number (to be inserted following presentation to committee)		

Please send to Balvinder Everitt or Michelle Dunne, Equality, Diversity and Inclusion for Quality Assurance.

Once you have committee sign off, please send to Caroline Higgs, Communications & Engagement Team for publication: bsol.comms@nhs.net