# Equality Analysis

***(Health Inequalities, Human Rights, Social Value)***

# Policy for the use of Image Guided Therapeutic Intra-Articular Joint 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 Therapeutic Intra-Articular Joint Injections. | | |
| **EA Author** | David King | **Team** | Equality & Diversity Team |
| **Date Started** | 13/8/2019 | **Date Completed** | 13/8/2019 |
| **EA Version** | 2 | **Reviewed by E&D** | |

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

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].

**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 | 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 |
|---|---|---|
| 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<br>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.

## 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 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.

**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.

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

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

| 3. Impact and Evidence: |
|---|
| **Race:** Describe race related impact and evidence**.** This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers:<br><br>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:<br><br>No impact identified |
| **Sex:** Describe any impact and evidence on men and women. This could include access to services and employment:<br><br>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:<br><br>No impact identified |
| **Carers:** Describe any impact and evidence on part-time working, shift-patterns, general caring responsibilities:<br><br>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, looked after children, single parent households, victims of domestic abuse, victims of drugs / alcohol abuse: (This list is not exhaustive)<br><br>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?** | | |

| 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 and NICE guidance |
| **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 impact of evidence from 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 informed decisions and choices | How will individuals have the opportunity to be involved in discussions and decisions about their own healthcare? | An individual can discuss the impact with their GP 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 impact of evidence from this policy |
| Right to **Liberty** | Will or could someone be deprived of their liberty? How? | No impact of evidence from 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 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.

## 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**