NHS
Cheshire and Merseyside

Clinical Commissioning Policy

Osteoarthritis-induced joint pain, secondary care administration of intra-articular corticosteroids

Category 2 Intervention - Only routinely commissioned when specific criteria are met -

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Purpose	This document is part of a suite of policies that the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite.
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Document control:		
Date:	**Version Number:**	**Section and Description of Change**
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1. Introduction

1.1 This policy relates to the commissioning of interventions which optimise clinical effectiveness and represent value for money.

1.2 This document is part of a suite of policies which the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy is a separate public document in its own right but should be considered alongside all the other policies in the suite as well as the core principles outlined in Appendix 1.

1.3 At the time of publication, the evidence presented per procedure/treatment was the most current available.

2. Purpose

2.1 This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

3. Policy statement

3.1 The majority of intra-articular administration of corticosteroid injections should normally be performed in primary care.

3.2 Secondary care administration will only be commissioned if the patient fulfils any of the following criteria:

3.2.1 the technique is expected to be technically difficult (e.g. patient with severe osteoarthritis or obesity)

OR

3.2.2 patients who may require a knee arthroplasty in the very short-term future

OR

3.2.3 patients on immunosuppressants who are at greater risk of infection

OR

3.2.4 the secondary care clinician feels it would be beneficial for the injection to be administered, without delay, during a routine outpatient appointment.

4. Exclusions

4.1 None

5. Rationale

5.1 This policy restricts secondary care administration of intra-articular corticosteroid injections to those patients where the procedure is likely to be technically difficult or are at risk and are likely to require ultrasound guidance.

6. Underpinning evidence

6.1 Osteoarthritis is a syndrome which consists of joint pain accompanied by varying degrees of functional limitation and reduced quality-of-life. The most commonly affected peripheral joints are the knees, hips, ankle and thumb.[1] Progressive loss of a particular cartilage may result and there is no curative treatment.[2]

6.2 Intra-articular corticosteroid injections are used to deliver a high dose of steroid to a specific joint while minimising side effects. Although they have marked anti-inflammatory effects, any analgesic action is presumed to be related to these anti-inflammatory properties.[1] Evidence demonstrates that intra-articular injections provide a short-term (1 – 4 weeks) reduction in osteoarthritis pain but effect on function appears less marked. Other available evidence suggests there is no activity remaining 6 months after the injection.[3] These injections are widely used in practice and are probably most effective in the knee although there are some positive data for the hip and hand.

6.3 The risk of adverse effects is generally considered to be small [1] with some experiencing a transient increase in pain following injection and a small risk of infection. Care should always be taken when injecting small joints such as fingers to avoid traumatising local nerves. In one hospital-based study, there were very low rates of serious complications with only one in 5 patients requiring subsequent surgery. This study was limited to secondary care only with the availability of radiological image guidance.[4]

6.4 One of the advantages of administering intra-articular injections in secondary care is the availability of imaging to guide the introduction of the needle. For example, a comprehensive review of the literature demonstrated the increased accuracy of ultrasound-guided injections regardless of anatomic location. [5] In the upper extremity, ultrasound-guided injections have been shown to provide superior benefit to landmark guided (i.e. without imaging) injections at the shoulder joint, the biceps tendon sheath and the joints of the hand and wrist. Similarly, ultrasound-guided injections are superior than landmark guided ones at the knee, ankle and foot. More specifically, according to NHS England's Evidence-Based Interventions (EBI) document (https://www.aomrc.org.uk/ebi/wp-content/uploads/2021/05/ebi-statutory-guidance.pdf) intra-articular corticosteroid injections (amongst other things) are suitable for primary, community and intermediate care for frozen shoulder.

6.5 Information on administering intra-articular corticosteroid injections in primary care is limited. However, a 2011 review [6] of injection administration in the knee suggested that the procedure is usually performed in secondary care, but this is frequently being performed in primary care. It was also noted that accurate placement of the needle is not achieved in up to 20% of injections. In Northern Ireland, it was apparent that only a handful of GPs performed the majority of primary care injections and of these, most had had adequate prior hospital training. The authors concluded that some patients should be treated by experienced specialists (i.e. in secondary care) in those:

- with severe osteoarthritis,
- people who may require an imminent knee arthroplasty where the risk of infection could be catastrophic,
- rheumatoid patients receiving immunosuppressive therapy (due to infection risk) and in
- technically difficult cases such as obese patients.

6.6 The authors concluded that the majority of joint injections can safely be performed by GPs who have had prior training and there are certain patients for whom treatment by experienced specialists is advised.

6.7 In terms of national guidance, NICE's clinical guideline on osteoarthritis (CG 177) [1] recommends that 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. NICE doesn't comment on whether this is appropriate in primary or secondary care. Further, a review of international guidelines found the majority of current guidance is in favour of intra-articular corticosteroid for knee osteoarthritis.[7] Finally, a 2015 Cochrane review concluded that there may be efficacy for knee osteoarthritis in the short-term (although the evidence was unclear) but there was no evidence that the effect remains 6 months after an injection. [3]

6.8 In summary, intra-articular administration of corticosteroids is recommended by NICE for the treatment of pain in people with osteoarthritis. NICE doesn't comment on whether the setting should be primary or secondary care. One particular benefit of administration in secondary care is the availability of imaging to accurately guide the introduction of the needle. Of the limited evidence, which is available, other authors have suggested that specialist (secondary) care is appropriate in some patients with severe osteoarthritis, those who may require an imminent knee arthroplasty, patients on immunosuppressives and those where technically the procedure could be difficult e.g. in obese patients. Otherwise, primary care administration of intra-articular corticosteroids is considered to be safe and effective (in the short term) for the majority of patients.

REFERENCES

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7. Force

7.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance or other national directive relating to this intervention, or to alternative treatments for the same condition.

8. Coding

8.1 **Office of Population Censuses and Surveys (OPCS)**
None

8.2 **International classification of diseases (ICD-10)**
None

9. Monitoring And Review

9.1 This policy may be subject to continued monitoring using a mix of the following approaches:
- Prior approval process
- Post activity monitoring through routine data
- Post activity monitoring through case note audits

9.2 This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding effectiveness and value.

10. Quality and Equality Analysis

10.1 Quality and Equality Impact Analyses have been undertaken for this policy at the time of its review.

Appendix 1 - Core Objectives and Principles

Objectives

The main objective for having healthcare commissioning policies is to ensure that:

- Patients receive appropriate health treatments
- Treatments with no or a very limited evidence base are not used; and
- Treatments with minimal health gain are restricted.

Principles

This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

Commissioning decisions by ICB Commissioners are made in accordance with the commissioning principles set out as follows:

- Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
- Commissioners require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
- Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
- Commissioners will balance the needs of an individual patient against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
- Commissioners will consider all relevant national standards and consider all proper and authoritative guidance.
- Where a treatment is approved Commissioners will respect patient choice as to where a treatment is delivered, in accordance with the 'NHS Choice' framework.
- Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

Core Eligibility Criteria

There are a number of circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for the procedures and treatments listed, regardless of whether they meet the criteria; or the procedure or treatment is not routinely commissioned.

These core clinical eligibility criteria are as follows:

- Any patient who needs 'urgent' treatment will always be treated.
- All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
- NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England.
- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- For patients wishing to undergo Gender reassignment, this is the responsibility of NHS England and patients should be referred to a Gender Identity Clinic (GIC) as outlined in the Interim NHS England Gender Dysphoria Protocol and Guideline 2013/14.

Cosmetic Surgery

Cosmetic surgery is often carried out to change a person's appearance to achieve what a person perceives to be a more desirable look.

Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely commissioned by the ICB Commissioner.

A summary of Cosmetic Surgery is provided by NHS Choices. Weblink:
http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

Diagnostic Procedures

Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should not be carried out unless the eligibility criteria are met, or approval has been given by the ICB or GP (as set out in the approval process of the patients responsible ICB) or as agreed by the IFR Panel as a clinically exceptional case.

Where a General Practitioner/Optometrist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrist/Dentist, in order for them to make a decision on future treatment.

Clinical Trials

The ICB will not fund continuation of treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

Clinical Exceptionality

If any patients are excluded from this policy, for whatever reason, the clinician has the option to make an application for clinical exceptionality. However, the clinician must make a robust case to the Panel to confirm their patient is distinct from all the other patients who might be excluded from the designated policy.

The ICB will consider clinical exceptions to this policy in accordance with the Individual Funding Request (IFR) Governance Framework consisting of: IFR Decision Making Policy; and IFR Management Policy.