NHS
Coventry and Warwickshire
Integrated Care Board

Policy for Primary Hip and Knee Replacement Surgery (with or without Patella Replacement or Resurfacing)

Reference Number:	COM 45
Version:	V1
Name of responsible Committee and date approved or recommended to Integrated Care Board:	Finance and Performance Committee
Date approved by the Integrated Care Board (if applicable):	05 February 2025
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Expiry Date:	February 2028
Name of author and title:	Public Health Warwickshire & ICB Medical Directorate
Name of reviewer and title:	Dr Mike Caley, Deputy Chief Medical Officer
Department:	Medical Directorate

VERSION HISTORY

Date	Version	Changes made to previous version	Consulting and Endorsing Stakeholders, Committees / Meetings / Forums etc.

Contents

1. Category: Prior Approval

Prior approval from the Integrated Care Board (ICB) will be required before any treatment proceeds in secondary care unless an alternative contract arrangement has been agreed with the ICB that does not necessitate the requirement of prior approval before treatment.

2. Background

This policy applies only to elective primary hip or knee replacement for osteoarthritis.

The majority of patients with osteoarthritis (OA) of the hip or knee can initially be managed adequately in primary and intermediate care by following the NICE Clinical Guideline 226 (2022) and Quality Standard 87 (2015) for care and management of OA.

3. Indication

The most common indication for elective primary total hip replacement (THR) is degenerative arthritis (osteoarthritis) of the joint. Other indications include rheumatoid arthritis, injury, bone tumour and necrosis of the hip bone.

The most common indication for elective primary total knee replacement (TKR) is degenerative arthritis (osteoarthritis) of the joint. Other indications include rheumatoid arthritis, osteonecrosis and other types of inflammatory arthritis.

Adults aged 45 or over can be diagnosed with OA clinically, without investigations if they have activity-related joint pain and any morning joint stiffness lasts no longer than 30 minutes. Primary or intermediate care x-ray is not necessary as part of routine investigations.

TKR with resurfaced patella

The ICB has reviewed NICE (NG157) guideline and wider literature via PubMed of the evidence for clinical and cost effectiveness of patellar resurfacing as part of primary TKR. The ICB has concluded that there is an overall financial benefit to patellar resurfacing, with patients more likely to need revisions, and seek more primary and secondary care appointments, where resurfacing has not taken place.

On this basis, the decision as to whether Patellar resurfacing as part of primary TKR should take place is to be made during the primary TKR operation by the treating clinical team.

4. Eligibility Criteria

Referral for specialist assessment can be considered for patients who meet all the following criteria 1 – 6:

1. Patient experiences joint symptoms (pain, stiffness and reduced function) that have a substantial impact on their quality of life defined as interfering with their activities of daily living or their ability to sleep.

2. Patient has been offered at least the core (non-surgical) treatment options recommended by NICE NG226;

- Advise people with osteoarthritis where they can find further information on:
    - osteoarthritis and how it develops (including flares and progression over time), and information that challenges common misconceptions about the condition

- activity and therapeutic exercise tailored to their needs appropriate to age, comorbidity, pain severity or disability. Exercise should include local muscle strengthening and general aerobic fitness.
- managing their symptoms
- how to access additional sources of information and support after consultations, such as peer-to-peer support and support groups
- benefits and limitations of treatment.

- referral to a recognised weight management programme for patients who are overweight or obese to improve outcomes. Evidence shows that lower BMIs have better surgical outcomes and therefore, patients who are overweight and obese must be offered support and interventions to lose weight and those who are obese must be offered a recognised weight management programme. This should be documented.
- All overweight and obese patients will be reviewed pre-operatively by the surgeon to ascertain medical fitness for surgery. Patient specific factors (including age, sex, smoking, obesity and co-morbidities) should not be barriers for surgery, however, patients who smoke should be advised to attempt to stop smoking at least 4 weeks before surgery to reduce the risk of surgical and post-surgery complications.

3. Joint symptoms are refractory to non-surgical treatments listed below including where appropriate; analgesia, steroid injections, local heat and cold therapy.
4. Patients have a right to be fully informed about this procedure. As part of this process, clinicians should engage the patients (or their carers) in shared decision making about alternative management and the risks and benefits of surgery.
5. Patient has confirmed they wish to have surgery.
6. Any underlying medical conditions have been investigated and the patient's condition has been optimised.

5. Further advice and support

Currently some of this information is available on national websites, such as the Versus Arthritis (https://www.versusarthritis.org/about-arthritis/conditions/osteoarthritis/) however it has not been standardised in any way. Each hospital should have its own locally written information to distribute to patients in clinic. This local information may differ between centres, reflecting local practice, but there is no national standard for this information. The ICB expectation is that the information provided to patients includes the following as a minimum:

- Agree individualised self-management strategies with the person with osteoarthritis.
- Manual therapy (such as manipulation, mobilisation or soft

tissue techniques) should only be considered for people with hip or knee osteoarthritis and alongside therapeutic exercise. If discussing manual therapy, explain to people with osteoarthritis that there is not enough evidence to support its use alone for managing osteoarthritis.

- Devices –
  - Consider walking aids (such as walking sticks) for people with lower limb osteoarthritis.
  - Do not routinely offer insoles, braces, tape, splints or supports to people with osteoarthritis unless:

        - there is joint instability or abnormal biomechanical loading and
        - therapeutic exercise is ineffective or unsuitable without the addition of an aid
        - or device and
        - the addition of an aid or device is likely to improve movement and function.

- Pharmacological management
    - If pharmacological treatments are needed to manage osteoarthritis, use them alongside non-pharmacological treatments and to support therapeutic exercise and at the lowest effective dose for the shortest possible time.
    - Offer a topical non-steroidal anti-inflammatory drug (NSAID) to people with knee osteoarthritis.
    - Consider a topical NSAID for people with osteoarthritis that affects other joints.
    - If topical medicines are ineffective or unsuitable, consider an oral NSAID for people with osteoarthritis and take account of:
        - potential gastrointestinal, renal, liver and cardiovascular toxicity
        - any risk factors the person may have, including age, pregnancy, current medication and comorbidities.
        - Offer a gastroprotective treatment (such as a proton pump inhibitor) for people with osteoarthritis while they are taking an NSAID.
    - Do not routinely offer paracetamol or weak opioids unless:
        - they are only used infrequently for short-term pain relief **and**
        - all other pharmacological treatments are contraindicated, not tolerated or ineffective.
    - Explain to people with osteoarthritis that there is no strong evidence of benefit for paracetamol. For more information about opioids, see NICE's guideline on medicines associated with dependence or withdrawal symptoms.
- Do not offer glucosamine or strong opioids to people to manage osteoarthritis.
- If the person with osteoarthritis asks about glucosamine or strong opioids, explain that:
    - there is no strong evidence of benefit for glucosamine
    - the risks of strong opioids outweigh the benefits.
    - Review with the person whether to continue treatment. Base the frequency of reviews on clinical need.
- Intra-articular injections
    - Do not offer intra-articular hyaluronan injections to manage osteoarthritis.
    - Consider intra-articular corticosteroid injections when other pharmacological treatments are ineffective or unsuitable, or to support therapeutic exercise. Explain to the person that these only provide short-term relief (2 to 10 weeks).
- Patients who smoke should be advised to attempt to stop smoking at least 4 weeks before surgery to reduce the risk of surgical and post-surgery complications.

For patients who DO NOT meet the eligibility criteria, the ICB will only consider funding the treatment if an Individual Funding Request (IFR) detailing the patient's clinical presentation is submitted to the ICB.

6. Guidance/References

https://www.nice.org.uk/guidance/ng157/resources/joint-replacement-primary-hip-knee-and-shoulder-pdf-66141845322181

https://www.nice.org.uk/guidance/ng226/resources/osteoarthritis-in-over-16s-diagnosis-and management-pdf-66143839026373

https://www.nice.org.uk/guidance/qs87/resources/osteoarthritis-in-over-16s-pdf-2098913613253

https://www.nice.org.uk/guidance/ng226/evidence/e-clinical-and-cost-effectiveness-of-manual-therapy-for-the-management-of-osteoarthritis-pdf-11250452850

https://www.nice.org.uk/guidance/mtg76/resources/aposhealth-for-knee-osteoarthritis-pdf-64372240535749

https://www.versusarthritis.org/about-arthritis/conditions/osteoarthritis/

Boyce, L., Prasad, A., Barrett, M. et al. The outcomes of total knee arthroplasty in morbidly obese patients: a systematic review of the literature. Arch Orthop Trauma Surg 139, 553–560 (2019). https://doi.org/10.1007/s00402-019-03127-5

Surakanti A, Demory Beckler M, Kesselman MM. Surgical Versus Non-Surgical Treatments for the Knee: Which Is More Effective? Cureus. 2023 Feb 11;15(2):e34860. doi: 10.7759/cureus.34860. Erratum in: Cureus. 2023 Jul 14;15(7):c129. PMID: 36923205; PMCID: PMC10010196.

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7. Diagnostic and Procedure Codes

Total Hip Replacement

Primary OPCS:

W37.1: Primary total prosthetic replacement of hip joint using cement
W37.9: Unspecified total prosthetic replacement of hip joint using cement
W38.1: Primary total prosthetic replacement of hip joint not using cement
W38.9: Unspecified total prosthetic replacement of hip joint not using cement
W39.1: Primary total prosthetic replacement of hip joint NEC
W39.9: Unspecified other total prosthetic replacement of hip joint
W93.1: Primary hybrid prosthetic replacement of hip joint using cemented acetabular component
W93.9: Unspecified hybrid prosthetic replacement of hip joint using cemented acetabular component
W94.1: Primary hybrid prosthetic replacement of hip joint using cemented femoral component
W94.9: Unspecified hybrid prosthetic replacement of hip joint using cemented femoral component
W95.1: Primary hybrid prosthetic replacement of hip joint using cement NEC
W95.9: Unspecified hybrid prosthetic replacement of hip joint using cement

Secondary OPCS:

Bilateral:

Z94.1: Bilateral operation or

Z94.2: Right sided operation and Z94.3: Left sided operation
Unilateral:
Z94.2: Right sided operation or
Z94.3: Left sided operation or
Z94.4: Unilateral operation

Total Knee Replacement
Primary OPCS:
W40.1: Primary total prosthetic replacement of knee joint using cement
W40.9: Unspecified total prosthetic replacement of knee joint using cement
W41.1: Primary total prosthetic replacement of knee joint not using cement
W41.9: Unspecified total prosthetic replacement of knee joint not using cement
W42.1: Primary total prosthetic replacement of knee joint NEC
W42.9: Unspecified other total prosthetic replacement of knee joint
O18.1: Primary hybrid prosthetic replacement of knee joint using cement
O18.9: Unspecified hybrid prosthetic replacement of knee joint using cement

8. Equality and Quality Impact Assessment Tool

The following assessment screening tool will require judgement against all listed areas of risk in relation to quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations.

Insert your assessment as positive (P), negative (N) or neutral (N/A) for each area.
Record your reasons for arriving at that conclusion in the comments column. If the assessment is negative, you must also calculate the score for the impact and likelihood and multiply the two to provide the overall risk score. Insert the total in the appropriate box.

Quality Impact Assessment

Quality and Equality Impact Assessment

Scheme Title:	Policy for Primary Knee Replacement Surgery		
Project Lead:	Lucy Dyde, IFR Team Manager	**Senior Responsible Officer:**	Dr Michael Caley, Deputy CMO
		Quality Sign Off:	Quality Team Members
Intended impact of scheme:	To provide a fair, equitable and transparent process for all patients of the NHS Coventry and Warwickshire Integrated Care Board (ICB), for which the ICB has commissioning responsibility. The Policy for Primary Hip and Knee Replacement Surgery (with or without Patella Replacement or Resurfacing) supports the objective to prioritise resources and provide interventions with the greatest proven health gain, within ICB budgetary constraints. The intention is to ensure equity and fairness in respect of access to NHS funding for interventions and to ensure that interventions are provided within the context of the needs of the overall population and the evidence of clinical and cost effectiveness and desired outcomes for patients it is intended for.		
How will it be achieved:	Through the process detailed in this document.		

Name of person completing assessment:	Lucy Dyde
Position:	IFR Team Manager
Date of Assessment:	06.11.2024

Quality Review by:	
Position:	
Date of Review:	

High level Quality and Equality Questions

The risk rating is only to be done for the potential negative outcomes. We are looking to assess the likelihood of the negative outcome occurring and the level of negative impact. We are also seeking detail of mitigation actions that may help reduce this likelihood and potential impact.

AREA OF ASSESSMENT		**OUTCOME ASSESSMENT** (Please tick one)			**Evidence/Comments for answers**	**Risk rating** (For negative outcomes)			**Mitigating actions**
		Positive	**Negative**	**Neutral**		**Risk impact** (I)	**Risk likelihood** (L)	**Risk Score** (IxL)	
Duty of Quality Could the scheme impact positively or negatively on any of the following:	Effectiveness – clinical outcome	✓			Policy to implement access for eligible patients to receive clinically effective NHS funded treatment following NICE NG226, NG157, QS87, PubMed national evidenced based				

					guidance.				
	Patient experience	✓			Policy to implement access for eligible patients who will be assured that they are accessing evidenced based practice to receive clinically effective NHS funded treatment.				
	Patient safety	✓			The provider will follow the Patient Safety Incident Response Framework (PSIRF) national guidance on reporting incidents via the Learning from Patient Safety Events (LFPSE) system as per individual policy/procedures to protect patients and maintain safety.				
	Parity of esteem	✓			Policy to implement access for eligible patients to receive clinically appropriate treatment which includes access to mental health and physical health support within the designated service, where applicable following NICE NG226, NG157, QS87, PubMed national evidenced based guidance.				
	Safeguarding children or adults	✓			Usual ICB and/or Provider Safeguarding policies and				

					mechanisms will apply.				
NHS Outcomes Framework Could the scheme impact positively or negatively on the delivery of the five domains:	Enhancing quality of life	✓			Patients eligible for NHS funded treatment will experience improved access to service and desired outcome.				
	Ensuring people have a positive experience of care	✓			Increased opportunity for patients to access the service locally and nationally via patient choice.				
	Preventing people from dying prematurely			✓	Policy to implement access for eligible patients to receive clinically effective treatment.				
	Helping people recover from episodes of ill health or following injury	✓			Patients eligible for this NHS funded treatment will help them recover from Hip and/or Knee degeneration.				
	Treating and caring for people in a safe environment and protecting them from avoidable harm	✓			The ICB expectation is that all providers of service hold an NHS standard contract where delivery of the service is stipulated under the core requirements to safeguard quality of care in line with the Care Quality Commission (CQC) “quality statements”.				
Patient services Could the proposal impact positively or negatively on any	A modern model of integrated care, with key focus on multiple long-term conditions and	✓			Patients eligible for this NHS funded treatment will help them recover from ill health related conditions				

of the following:	clinical risk factors				resulting in Knee degeneration.				
	Access to the highest quality urgent and emergency care			✓	Policy to implement national evidenced based guidance for eligible patients to receive clinically effective NHS funded treatment following NICE NG226, NG157, QS87, PubMed national evidenced based guidance.				
	Convenient access for everyone	✓			This policy applies to all patients registered at an NHS Coventry and Warwickshire ICB GP practice and is available under patient choice for eligible patients to receive NHS funded treatment.				
	Ensuring that citizens are fully included in all aspects of service design and change	✓			Nationally patient engagement and participation has been key to the policy design Patients are invited to participate in current providers National/Local staff satisfaction surveys to ensure ongoing engagement continues.				
	Patient Choice	✓			This policy applies to all patients registered at an NHS Coventry and Warwickshire ICB GP practice and is available under patient choice for eligible patients to receive				

					clinically effective NHS funded treatment.				
	Patients are fully empowered in their own care	✓			Eligible patients will be fully involved in their care planning through shared decision-making, personalised care, and support planning following NICE NG226, NG157, QS87, PubMed national evidenced based guidance.				
	Wider primary care, provided at scale			✓	Policy to implement national evidenced based guidance for eligible patients to receive clinically effective NHS funded treatment within the Secondary Care services under patient choice.				
Access Could the proposal impact positively or negatively on any of the following:	Patient choice	✓			This policy applies to all patients registered at an NHS Coventry and Warwickshire ICB GP practice and is available under patient choice for eligible patients to receive clinically effective NHS funded treatment.				
	Access	✓			This policy applies to all patients registered at an NHS Coventry and Warwickshire ICB GP practice and is available under patient choice for eligible patients to receive				

					clinically effective NHS funded treatment within the Secondary Care services under patient choice.				
	Integration	✓			There is collaboration across the pathway at system level across primary and secondary care.				
Compliance with NHS Constitution	Quality of care and environment	✓			The ICB expectation is that all providers of service hold an NHS standard contract where delivery of the service is stipulated under the core requirements to safeguard quality of care in line with the Care Quality Commission (CQC) “quality statements”.				
	Nationally approved treatment/drugs	✓			Policy to implement national evidenced based guidance for eligible patients to receive clinically effective NHS funded treatment following NICE NG226, NG157, QS87, PubMed national evidenced based guidance.				
	Respect, consent and confidentiality	✓			All usual ICB and/or Provider respect, consent and confidentiality policies and mechanisms will apply.				

	Informed choice and involvement	✓			Patients will be fully involved in their care planning through shared decision-making, personalised care, and support planning NICE NG226, NG157, QS87, PubMed national evidenced based guidance.				
	Complain and redress	✓			Usual ICB and/or Provider compliment, complaint and redress policies and mechanisms will apply				

*Risk score definitions are provided in the next section.

Equality Impact Assessment

Project / Policy Details

What is the aim of the project / policy?
To provide a fair, equitable and transparent process for all patients of the NHS Coventry and Warwickshire Integrated Care Board (ICB), for which the ICB has commissioning responsibility. The Policy for Primary Hip and Knee Replacement Surgery (with or without Patella Replacement or Resurfacing) supports the objective to prioritise resources and provide interventions with the greatest proven health gain, within ICB budgetary constraints. The intention is to ensure equity and fairness in respect of access to NHS funding for interventions and to ensure that interventions are provided within the context of the needs of the overall population and the evidence of clinical and cost effectiveness and desired outcomes for patients it is intended for.

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

Is a full Equality Analysis Required for this project?			
Yes	Proceed to complete this form.	No	Explain why further equality analysis is not required.
If no, explain below why further equality analysis is not required. For example, the decision concerned may not have been made by the ICB or it is very clear that it will not have any impact on patients or staff.			

Equality Analysis Form

1. Evidence used
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.
https://www.nice.org.uk/guidance/ng157/resources/joint-replacement-primary-hip-knee-and-shoulder-pdf-66141845322181 https://www.nice.org.uk/guidance/ng226/resources/osteoarthritis-in-over-16s-diagnosis-and management-pdf-66143839026373 https://www.nice.org.uk/guidance/qs87/resources/osteoarthritis-in-over-16s-pdf-2098913613253

https://www.nice.org.uk/guidance/ng226/evidence/e-clinical-and-cost-effectiveness-of-manual-therapy-for-the-management-of-osteoarthritis-pdf-11250452850

https://www.nice.org.uk/guidance/mtg76/resources/aposhealth-for-knee-osteoarthritis-pdf-64372240535749

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2. 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: A person belonging to a particular age (e.g. 32 year olds) or a range of ages (e.g. 18-30 year olds)
This policy does not contain any statements which may exclude clinicians of the NHS Coventry and Warwickshire Integrated Care Board from applying this policy.
Disability: A person has a disability if he/she has a physical, hearing, visual or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities
This policy does not contain any statements which may exclude clinicians of the NHS Coventry and Warwickshire Integrated Care Board from applying this policy.
Gender reassignment (including transgender): Where a person has proposed, started or completed a process to change his or her sex.
This policy does not contain any statements which may exclude clinicians of the NHS Coventry and Warwickshire Integrated Care Board from applying this policy.
Marriage and civil partnersKnee: A person who is married or in a civil partnersKnee.
This policy does not contain any statements which may exclude clinicians of the NHS Coventry and Warwickshire Integrated Care Board from applying this policy.

Pregnancy and maternity: A woman is protected against discrimination on the grounds of pregnancy and maternity. With regard to employment, the woman is protected during the period of her pregnancy and any statutory maternity leave to which she is entitled. Also, it is unlawful to discriminate against women breastfeeding in a public place.
This policy does not contain any statements which may exclude clinicians of the NHS Coventry and Warwickshire Integrated Care Board from applying this policy.
Race: A group of people defined by their race, colour, and nationality (including citizensKnee) ethnic or national origins.
This policy does not contain any statements which may exclude clinicians of the NHS Coventry and Warwickshire Integrated Care Board from applying this policy. There is a higher prevalence of MSK conditions among some ethnic minorities compared with white people (Allison et al., 2002). The same study found MSK pain is more widespread among ethnic minorities and conclude that this may reflect social, cultural and psychological differences.
Religion or belief: A group of people defined by their religious and philosophical beliefs including lack of belief (e.g. atheism). Generally a belief should affect an individual's life choices or the way in which they live.
This policy does not contain any statements which may exclude clinicians of the NHS Coventry and Warwickshire Integrated Care Board from applying this policy.
Sex: A man or a woman
This policy does not contain any statements which may exclude clinicians of the NHS Coventry and Warwickshire Integrated Care Board from applying this policy. Globally, women account for 60% of people with osteoarthritis, with a greater difference after age 40. The higher risk for women may be due to differences in joint anatomy, alignment, muscle strength, hormonal influences, obesity, and/or genetics. At the same radiographic severity, women have greater pain severity than men, which may be explained by biologically distinct pain pathways, differential activation of central pain pathways, differences in pain sensitivity, perception, reporting, and coping strategies. Women have greater limitations of physical function and performance than men independent of BMI, OA severity, injury history, and amount of weekly exercise. Women also have greater use of analgesic medications than men but less use of arthroplasty and poorer prognosis after surgical interventions.
Sexual orientation: Whether a person feels generally attracted to people of the same gender, people of a different gender, or to more than one gender (whether someone is heterosexual, lesbian, gay or bisexual).
This policy does not contain any statements which may exclude clinicians of the NHS Coventry and Warwickshire Integrated Care Board from applying this policy.
Carers: A person who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support

This policy does not contain any statements which may exclude clinicians of the NHS Coventry and Warwickshire Integrated Care Board from applying this policy.

There is local evidence that those from more deprived areas are more likely to be carers. We know population aged over 85 is set to double in the next 5 years. The biggest increases in people becoming carers are likely to also be in over 65s- so this policy could affect both people who are caring, and the people caring for them. Older people in need of care is predicted to outstrip the number of family members able to provide it.

Other disadvantaged groups:

This policy does not contain any statements which may exclude clinicians of the NHS Coventry and Warwickshire Integrated Care Board from applying this policy.

https://www.thelancet.com/journals/lanepe/article/PIIS2666-7762(22)00171-5/fulltext
Having adjusted for age and sex, people living in the most deprived quintile were 2.36 (95% CI, 1.69 to 3.29) times more likely to need a hip replacement in 2006 than those living in quintile 3, whereas those living in the least deprived quintile were 0.45 (95% CI, 0.39 to 0.69) as likely. Despite this, people living in the most deprived quintile were 0.81 (95% CI, 0.78 to 0.83) times as likely in England and 0.93 (95% CI, 0.84 to 1.04) as likely in Wales to receive an NHS-funded hip replacement in 2006 than those living in quintile 3. We found no evidence that these substantial inequities had reduced between 2006 and 2016.

https://pmc.ncbi.nlm.nih.gov/articles/PMC8506083/
Although socioeconomic inequality has somewhat decreased, lower SES patients and ethnic minority patients demonstrate increased surgical needs, reduced access and poor outcomes. Lower SES and Black minority patients were younger and had more comorbidities. Surgical need increased with age. Women had greater surgical need and provision than men. Geographical inequality had reduced in Scotland, but a north-south divide persists in England. Rural areas received greater provision relative to need, despite increased travel for care. In all, access inequalities remain widespread and policy change driven by research is needed.

The ICB is not aware of any other vulnerable and disadvantaged groups that are not already covered by other equality groups identified within the EIA.

3. Human Rights

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?	To provide a fair, equitable and transparent process for all patients of the NHS Coventry and Warwickshire Integrated Care Board (ICB), for which the ICB has commissioning responsibility.

		The Policy for Primary Hip and Knee Replacement Surgery (with or without Patella Replacement or Resurfacing) the objective to prioritise resources and provide interventions with the greatest proven health gain, within ICB budgetary constraints. The intention is to ensure equity and fairness in respect of access to NHS funding for interventions and to ensure that interventions are provided within the context of the needs of the overall population and the evidence of clinical and cost effectiveness.
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?	The patient will not be contacted by the ICB. If the patient contacts the ICB of their own accord then all communication, written or verbal, will be provided in a confidential, clear, understandable, format.
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?	This policy is applied to all patients of the NHS Coventry and Warwickshire Integrated Care Board to prioritise resources and provide interventions with the greatest proven health gain, within ICB budgetary constraints. The intention is to ensure equity and fairness in respect of access to NHS funding for interventions and to ensure that interventions are provided within the context of the needs of the overall population and the evidence of clinical and cost effectiveness.

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?	All communication, written or verbal, will be provided in a confidential, clear, understandable, format.
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?	Individuals will have the opportunity to discuss their healthcare with the requesting clinician. If the patient contacts the ICB of their own accord then all communication, written or verbal, will be provided in a confidential, clear, understandable, format.
Right to **Life**	Will or could it affect someone's right to life? How?	No
Right to **Liberty**	Will or could someone be deprived of their liberty? How?	No

4. 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
N/A	N/A	N/A

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 …..):

N/A

5. 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.

N/A

6. How will you measure how the proposal impacts health inequalities?
e.g Patients with a learning disability were accessing cancer screening in substantially lower numbers than other patients. By revising the pathway the ICB is able to show increased take up from this group, this is a positive impact on health inequalities. You can also detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract.
Requests will be managed on a prior approval basis by the IFR team. Activity is monitored through Acute Contracting/Business Intelligence who will monitor the activity and review as appropriate.

7. Is further work required to complete this assessment?			
Please state 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	**Section**	**When**	**Date completed**
N/A	N/A	N/A	N/A

8. Sign off		
The Equality Analysis will need to go through a process of **quality assurance** by a Senior Manager within the department responsible for the service concerned before being submitted to the Policy, Procedure and Strategy Assurance Group for approval. Committee approval of the policy / project can only be sought once approval has been received from the Policy, Procedure and Strategy Assurance Group.		
Requirement	**Name**	**Date**
Senior Manager Signoff	Dr Michael Caley, Deputy CMO	07.11.2024
Which committee will be considering the findings and signing off the EA?	F&P	05.02.2025
Approved by the Policy Procedure and Strategy Assurance Group.		

Once complete, please send to the ICB's Governance Team.