

Equality Impact Assessment (EIA) - Evidence Form

The PCT strives to design and implement services, policies and measures that meet the diverse needs of our service population and workforce, ensuring that none are placed at a disadvantage over others. This form is designed to help you to consider the needs and assess the positive, adverse or neutral impact of your policy, protocol, proposal or service on all groups within our local communities, and to record the evidence that you have done so. Any proposal or policy submitted to the Board must have undergone EIA.

This form will be used as evidence of the assessment you have undertaken. It will need to be made available to the Board and PCT's Equality and Diversity Steering Group.

Policy/Proposal/Service Title	Threshold policies – hip and knee replacement
Name of EIA Lead	Frances Fairman, Clinical Effectiveness Principal
Others involved in assessment	Dr Ljuba Stirzaker, Consultant in Public Health Medicine – Health Care Priorities
Date EIA commenced	3 November 2010

EIA Completed and Approved**Signature (Lead Director):** _____**Name (print)** _____**Job Title:** _____**Date:** _____

ONCE COMPLETED, PLEASE SUBMIT TO EQUALITY AND DIVERSITY LEAD FOR EVIDENCE AND PUBLICATION.

STAGE 1: Standard Screening

Background

Estimates suggest that up to 8.5 million people in the UK are affected by joint pain that may be attributed to osteoarthritis (Arthritis Care 2004). Osteoarthritis is the principle indication for hip and knee replacement surgery. Osteoarthritis at individual joint sites (notably knee, hip and hand) demonstrates consistent age-related increases in prevalence (Arthritis and Musculoskeletal Alliance 2004). The number of people with osteoarthritis in the UK is increasing as the population ages, and as the prevalence of risk factors such as obesity and poor levels of physical fitness also continues to rise (NICE 2008).

Knee osteoarthritis is highly variable in its outcome. Improvement in the structure of the joint is rare once the condition has become established. However, improvement in pain and disability over time is common. The data on clinical outcomes are sparse but it would seem that over a period of several years about a third of cases improve, a third stay much the same, and the remaining third of patients develop progressive symptomatic disease, requiring joint replacement. Little is known about the risk factors for progression, which may be different from those for initiation of the disease, but obesity probably makes an important contribution (NICE 2008).

Hip osteoarthritis probably has the worst overall outcome. As with the knee, relatively little is known about the natural history of symptomatic disease. Some hips heal spontaneously, with improvement shown radiographically as well as symptomatically but a significant number of people progress to a point where hip replacement is needed (NICE 2008).

Joint replacement is one of the most effective surgical procedures available. As a result, the demand from patients for these treatments continues to rise along with the confidence of surgeons to offer them to a wider range of patients in terms of age, disability and comorbidities (NICE 2008). In 2009/10 NHS Oxfordshire spent £4.2M on 707 hip replacement operations, and £2.5M on 480 knee replacements. NHS Oxfordshire saw a 20% increase in activity between 2004 and 2009.

Refs:

- Arthritis Care (2004) *OA nation*. London: Arthritis Care.
- Arthritis and Musculoskeletal Alliance (2004) *Standards of care for people with osteoarthritis*. London: ARMA.
- NICE (2008) *Osteoarthritis – National Clinical Guideline for the care and management of adults* The National Collaborating Centre for Chronic Conditions, Royal College of Physicians

EIA questions	EIA Narrative	Sources of Evidence
1. What is purpose and objectives of the policy, proposal or service?	The threshold policies for access to hip and knee replacement surgery have the following purposes: <ul style="list-style-type: none"> • To ensure that patients with the greatest clinical need, and who are likely to achieve the maximum health benefit, receive surgery in a timely manner • To reduce 'too early' intervention, which subjects patients to unnecessary risk and, potentially, the future need for revision surgery or other treatment 	In the development of the policies, clinical evidence was sought from: <ul style="list-style-type: none"> • Local clinical experts in primary and secondary care • National evidence sources, including: <ul style="list-style-type: none"> - NHS Evidence - PubMed - Clinical Knowledge Summaries - the Cochrane Library - Map of Medicine

Policy statements for hip and knee arthroplasty to Enhanced Clinical Executive, 11 November 2010

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	<ul style="list-style-type: none"> • To provide explicit thresholds for treatment to ensure equal access to surgery regardless of provider/where patients choose to be treated • To provide information that will support GPs in the management of their patients with osteoarthritis of the hip and knee <p>The significant changes from the current commissioning position are:</p> <ul style="list-style-type: none"> - the requirement that all patients who smoke consider undertaking a smoking cessation programme whilst they are on the waiting list for surgery. Giving up for even 6 weeks reduces the risks of infection and delayed wound healing. However, patients who refuse will not be denied surgery unless their specialist/anaesthetists considers the risks too great. - that patients who have a BMI>40 undertake a weight loss programme. The evidence shows that surgery is more complex, of longer duration and requires a longer hospital stay in people who are obese. 	<ul style="list-style-type: none"> - Dept Health (Patient Reported Outcomes report) - NICE (Clinical Guideline: Osteoarthritis – care and management of adults, 2008, Royal College of Physicians) <p>Cropley M, Theadom A, Pravettoni G, Webb G. The effectiveness of smoking cessation interventions prior to surgery: a systematic review. <i>Nicotine and Tobacco Research</i>.2008;10(3):407-412</p> <p>Thomsen T, Villebro N, Møller AM. Interventions for preoperative smoking cessation. <i>Cochrane Database of Systematic Reviews</i> 2010, Issue 7. Art. No.: CD002294. DOI: 10.1002/14651858.CD002294.pub3.</p> <p>Jain N, Guller U, Pietrobon, Bond T, Higgins L. Co-morbidities increase complication rates in patients having arthroplasty. <i>Clin Orthop</i> 2005; 435: 232–8.</p> <p>Jiganti J, Goldstein W, Williams C. A comparison of the perioperative morbidity in total joint arthroplasty in the obese and non-obese patients. <i>Clin Orthop</i> 1993; 289: 175–9.</p> <p>Moran M, Walmsly P, Brenkel I. Does BMI affect the outcome of primary cemented total hip replacement? <i>J Bone Joint Surg Br</i> 2004; 86 (Suppl): 81.</p> <p>McLaughlin JR, Lee KR. The outcome of total hip replacement in obese and non obese patients at 10- to 18-years. <i>J Bone Joint Surg Br</i> 2006; 88: 1286–92.</p> <p>Chan C, Villar R. Obesity and quality of life after primary hip arthroplasty. <i>J Bone Joint Surg Br</i> 1996; 78: 78–81. Miric A, Lim M, Kahn B, Rozenthal T. Perioperative morbidity following total knee arthroplasty among obese patients. <i>J Knee Surg</i> 2002; 15: 77. Winiarsky R, Barth P, Lotke P. Total knee arthroplasty in morbidly obese patients. <i>J Bone Joint Surg Am</i> 1998;</p>

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		<p>80: 1770–4. Foran JRH, Mont MA, Etienne G, Jones LC, Hungerford DS. The outcome of total knee replacements in obese patients. <i>J Bone Joint Surg Am</i> 2004; 86: 1609–16. Spicer D, Pomeroy D, Badenhausen Jr W, Schaper L, Curry J, Suthers K <i>et al.</i> Body mass index as a predicator of outcome in total knee replacement. <i>Int Orthop</i> 2001; 25: 246–9. Pasqualina L. Santaguida, Gillian A. Hawker, Pamela L. Hudak, Richard Glazier, Nizar N. Mahomed, Hans J. Kreder, Peter C. Coyte, James G. Wright, Patient characteristics affecting the prognosis of total hip and knee joint arthroplasty: a systematic review <i>J Can Chir</i>, Vol. 51, No 6, décembre 2008</p>
<p>2. Who is the policy, proposal or service aimed at?</p>	<p>The threshold policies are aimed at primary and secondary care clinicians (and tertiary centres).</p> <p>Analysis of Patient Reported Outcomes (PROMs) by the NHS Information Centre found that 5% of patients having hip replacements reported no change following surgery and 4% reported being in a worse health status. For knee replacement, the same study found that 10% of patients reported no change following surgery and 7.5% reported being in a worse health status.</p> <p>A patient who is not referred for surgery in the first instance can always be referred subsequently; a patient who has hip or knee arthroplasty too early, or inappropriately, cannot have it ‘undone’, and will potentially require revision/further surgery in the future. It is therefore important that clinicians, commissioners and patient representatives agree a threshold for this surgery to avoid inappropriate and high risk interventions and maximise health benefits.</p>	<p>Devlin N, Parkin D, Browne J <i>PROMs Pilot results</i> quoted by John Appleby, King’s Fund, available on line at: www.eoeleadership.nhs.uk/downloadFile.php?docJohn_Appleby AND Devlin N, Appleby J, <i>Getting the most out of PROMS</i>, King’s Fund, London, and Office of Health Economics, London: 2010</p> <p>Judge A, Welton NJ, Sandhu S, Ben-Shlomo Y. Equity in access to total joint replacement of the hip and knee in England: cross sectional study. <i>BMJ</i> 2010;341:c4092 doi:10.1136/bmj.c4092</p>

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<p>3. Does it affect one group less or more favourably than another (see groups below)?</p>	<p>Osteoarthritis predominantly affects older people, and often coexists with other conditions associated with aging and obesity, such as cardiovascular disease and diabetes, as well as with common sensory (eg, poor vision) and psychosocial problems (eg, anxiety, depression and social isolation). Osteoarthritis is associated with multiple risk factors, including:</p> <ol style="list-style-type: none"> 1. <i>genetic</i> factors (heritability estimates for hand, knee and hip osteoarthritis are high at 40–60%, though the responsible genes are largely unknown) 2. <i>constitutional</i> factors (eg, ageing, female sex, obesity, high bone density) 3. <i>local, biomechanical</i> risk factors (eg, joint injury, occupational/ recreational usage, reduced muscle strength, joint laxity, joint malalignment). <p>Some environmental/lifestyle risk factors are reversible (eg, obesity, muscle weakness) or avoidable (eg, occupational or recreational joint trauma) which has important implications for secondary and primary prevention. However, risk factors for <i>developing osteoarthritis</i> may differ from risk factors for <i>progression</i> and <i>poor clinical outcome</i> (eg high bone density is a risk factor for <i>development</i>, but low bone density is a risk factor for <i>progression</i> of knee and hip osteoarthritis).</p> <p>**Because of the clinical complexity of these factors, there is a need for individual assessment by primary and secondary care practitioners of the appropriateness of surgery. The threshold policies have addressed the issue by specifying the type of information-based consent that is required.</p> <p>**Further information, and links to resources, will be provided in the GP referral guidelines which are currently</p>	<p>NICE (2008) <i>Osteoarthritis – National Clinical Guideline for the care and management of adults</i> The National Collaborating Centre for Chronic Conditions, Royal College of Physicians</p> <p>**Statement in the threshold policies:</p> <p><i>“Prior to surgery the patient must be counseled regarding the benefits, risks, potential complications, and rehabilitation requirements associated with hip/knee arthroplasty. Informed consent to surgery AND subsequent rehabilitation programmes must be obtained”.</i></p>

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	in development to support policy implementation.	
Male or Females	<p>The prevalence of (radiographic) osteoarthritis is higher in women than men, especially after the age of 50 and for hand and knee osteoarthritis (NICE 2008).</p> <p>Evidence suggests that gender affects outcome from surgery as follows:</p> <ol style="list-style-type: none"> 1. <i>Peri-operative complications</i> Male gender was found to be a significant predictor of adverse events (AEs) arising from total knee replacement surgery. Males are at higher risk than females for AEs. 2. <i>Long-term survival of prosthesis</i> For total knee replacement surgery, men were significantly more likely than women to have knee revision surgery due to infection. <p>As highlighted at ** above, clinicians must obtain appropriate, informed consent to surgery. The clinical management of patients who agree to surgery is not otherwise addressed threshold policy, and the policy applies to people of either gender. The referral guideline for GPs (currently in development) will consider the management of patients who are not accepted for, or who do not wish to undertake, surgery.</p>	<p>NICE (2008) <i>Osteoarthritis – National Clinical Guideline for the care and management of adults</i> The National Collaborating Centre for Chronic Conditions, Royal College of Physicians</p> <p>Solomon DH, Chibnik LB, Losina E et al. (2006) Development of a preliminary index that predicts adverse events after total knee replacement. <i>Arthritis & Rheumatism</i> 54 (5): 1536–42. [Case series, N=124]</p> <p>Harrysson OLA, Robertsson O, Nayfeh JF (2004) Higher cumulative revision rate of knee arthroplasties in younger patients with osteoarthritis. <i>Clinical Orthopaedics & Related Research</i> 421: 162–8. [Case series, N=35,857]</p>
People of different ages	<p>Total knee replacement surgery</p> <ol style="list-style-type: none"> 1. <i>Peri-operative complications/hospital stay – evidence suggests the following:</i> <ul style="list-style-type: none"> - Patients in older age groups are more likely to be transferred to rehabilitation facilities (eg, older patients undergoing total knee replacement = 83%, younger patients 40%). 	<p>Jones CA, Voaklander DC, Johnston DW et al. (2001) The effect of age on pain, function, and quality of life after total hip and knee arthroplasty. <i>Archives of Internal Medicine</i> 161 (3): 454–60. [Case-series, N=454]</p>

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	<ul style="list-style-type: none"> - Older age (71–80 years or ≥81 years versus 65–70 years) is a significant predictor of AEs. - Older patients may have a higher mortality rate after total knee replacement 2. <i>Long-term survival of prosthesis – evidence suggests that for total knee replacement</i> <ul style="list-style-type: none"> - revision rates (any cause) are higher in younger patients (<60 years old) than the older group (≥60 years old) at 8.5 years post-surgery (13% and 6% respectively) – loosening of components is higher in younger patients (<60 years old) than the older group (≥60 years old) at 8.5 years post-surgery (6% and 2.5% respectively). - the risk for revision (any cause) is significantly lower (risk ratio 0.49, 95% CI 0.38 to 0.62, p<0.0001) in the older patients (≥60 years) compared with younger patients (<60 years) – the risk for loosening of components is significantly lower (risk ratio 0.41, 95% CI 0.27 to 0.62, p<0.0001) in the older patients (≥60 years) compared with younger patients (<60 years) –there is no significant difference between the older (≥60 years) and younger patients (<60 years), for risk of revision due to infection. 3. <i>Symptoms (pain, stiffness), function, QoL – evidence for the impact of age on outcomes of total knee replacement is mixed, with some studies reporting younger age was a predictor of poor outcome and others reporting that age was not a strong predictor of</i> 	<p>Solomon DH, Chibnik LB, Losina E et al. (2006) Development of a preliminary index that predicts adverse events after total knee replacement. <i>Arthritis & Rheumatism</i> 54 (5): 1536–42. [Case series, N=124]</p> <p>Gill GS, Mills D, Joshi AB (2003) Mortality following primary total knee arthroplasty. <i>Journal of Bone & Joint Surgery – American Volume</i> 85 (3): 432–5. [Case series – N=3,048]</p> <p>Harrysson OLA, Robertsson O, Nayfeh JF (2004) Higher cumulative revision rate of knee arthroplasties in younger patients with osteoarthritis. <i>Clinical Orthopaedics & Related Research</i> 421: 162–8. [Case series – N=35,857].</p> <p>Elson DW, Brenkel IJ (2006) Predicting pain after total knee arthroplasty. <i>Journal of Arthroplasty</i> 21 (7): 1047–53. [Case-series, N=512]</p> <p>Jones CA, Voaklander DC, Johnston DW et al. (2001) The effect of age on pain, function, and quality of life after total hip and knee arthroplasty. <i>Archives of Internal Medicine</i> 161 (3): 454–60 [Case-series, N=454]</p>

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	<p>postoperative pain or function. The results seem to be influenced by the length of the follow-up period.</p> <p>Total hip replacement surgery</p> <ol style="list-style-type: none"> 1. <i>Peri-operative complications/hospital stay</i> Evidence suggests that older patients are more likely to be transferred to rehabilitation facilities. 2. <i>Long-term survival of prosthesis</i> Evidence suggests that <ul style="list-style-type: none"> - older age is associated with increased risk of failure in patients aged ≥ 80 years (RR 1.6, 95% CI 1.0 to 2.6) compared with patients aged 60–69 years at 0–30 days after primary total hip replacement - younger age was associated with increased risk of failure in patients aged 10 to 49 years (RR 1.7, 95% CI 1.3 to 2.3) and patients aged 50 to 59 years (RR 1.3, 95% CI 1.0 to 1.6) compared with patients aged 60–69 years. - Patients aged 70–79 years and ≥ 80 years are associated with a lower risk for failure (RR 0.9, 95% CI 0.7 to 1.0) and (RR 0.6, 95% CI 0.5 to 0.8) respectively at 6 months to 8.6 years after primary hip replacement. <p>As highlighted at ** above, clinicians must obtain appropriate, informed consent to surgery. The clinical management of patients who agree to surgery is not otherwise addressed threshold policy: the policies provides for equal access to surgery for people of all ages, but managing specialists may agree with a patient that surgery is not appropriate for them because of clinical factors and risks associated with their age. The referral guideline for GPs (currently in development) will take account of the age of patients when considering aspects of</p>	<p>Lingard EA, Katz JN, Wright EA et al. (2004) Predicting the outcome of total knee arthroplasty. <i>Journal of Bone & Joint Surgery – American Volume 86–A</i> (10): 2179–86. [Case-series - N=860]</p> <p>Johnsen SP, Sorensen HT, Pedersen AB et al. (2006) Patient-related predictors of implant failure after primary total hip replacement in the initial, short- and long-term: a nationwide Danish follow-up study including 36,984 patients. <i>Journal of Bone & Joint Surgery – British Volume 88</i> (10): 1303–8. [Case-series]</p>

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	treatment such as analgesia.	
People of different ethnic groups	One study was found that compares the prevalence of osteoarthritis in Chinese and US populations: much lower levels of hip osteoarthritis were found in the Chinese, although levels of knee and hand osteoarthritis were similar. No information was found with regard to the progression of osteoarthritis and differential needs for surgery. The threshold policies do not apply differentially to people of different ethnic groups in terms of access to surgery.	Peat G, Thomas E, Duncan R et al. (2006) Clinical classification criteria for knee osteoarthritis: performance in the general population and primary care. <i>Annals of the Rheumatic Diseases</i> 65: 1363–7.
People of different religious beliefs	The threshold policies do not favour or disadvantage people of different religious beliefs in terms of access to surgery, although some people may choose not to undergo surgery where there is a risk of the need for donor blood transfusion (eg, Jehovah's Witnesses).	Department of Health UK Blood Transfusion Guidelines http://www.transfusionguidelines.org.uk/index.aspx?Publication=BBT&Section=22&pageid=1298
People who do not speak English as a first language	The threshold policies specify that people should be made fully aware of the risks and benefits of surgery and that appropriate information should be provided. Hospital Trusts have resources to facilitate this for patients who do not speak English as a first language. NHS Oxfordshire can facilitate support on request.	http://www.oxfordradcliffe.nhs.uk/aboutus/languages.aspx This web page describes the help available at the Oxford Radcliffe Trust to people who do not speak English as a first language. <i>NHS Choices are developing patient decisions aids for hip and knee replacement surgery and, when published in 2011, will be available in different languages.</i> http://www.oxfordshirepct.nhs.uk/EqualityAndDiversity/Pages/EthnicityandL.aspx
People who have a physical disability	Clinicians need to take physical comorbidities into account when considering a patient's individual risk for surgery. In particular, people who are obese or morbidly obese are at higher risk from surgery of any kind, and hip and knee replacement surgery is more complex in obese individuals. Obesity is associated with worse short-term outcomes: obesity is linked to perioperative and postoperative complications and increased length of hospital	Warren Davis, Matthew Porteous Joint replacement in the overweight patient: a logical approach or new form of rationing? <i>Ann R Coll Surg Engl</i> 2006; 89: 203–206 Pasqualina L. Santaguida, Gillian A. Hawker, Pamela L. Hudak, Richard Glazier, Nizar N. Mahomed, MD, Hans J. Kreder, Peter C. Coyte, James G. Wright. Patient characteristics affecting the prognosis of total hip and knee joint arthroplasty: a systematic review <i>J Can Chir</i> , Vol. 51, No 6,

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	<p>stay/rehabilitation. Knee replacement surgery in particular was associated with a higher rate of complications in obese and morbidly obese patients.</p> <p>With regard to symptoms (pain, stiffness), function, and quality of life following hip replacement, there is contradictory evidence that improvement in postoperative quality of life is significantly greater in the obese groups compared with the non-obese group. With regard to function and pain after knee arthroplasty, symptoms were worse for obese patients compared with those of 'normal' weight.</p> <p>The threshold policies advise primary care management of obesity prior to surgery, but weight/BMI is not an exclusion criterion, unless the patient's surgeon/anaesthetists considers the risk of surgery too great.</p>	<p>décembre 2008</p> <p>Montin L, Leino-Kilpi H, Suominen T, Lepisto J. A systematic review of empirical studies between 1966 and 2005 of patient outcomes of total hip arthroplasty and related factors <i>J Clin Nursing</i> (2008)17, 40–45</p> <p>NICE Clinical Guideline: <i>Osteoarthritis</i> (2008) CG59</p>
<p>People who have a mental disability</p>	<p>There is evidence patients with mental illness have poorer outcomes from hip and knee replacement surgery. The reasons are poorly understood but could be associated with delays in requesting treatment, and subsequent difficulties in complying with postoperative rehabilitation.</p> <p>The threshold policies do not exclude patients with mental illness from surgery, but there is a requirement for surgeons to confirm that a patient is fit for surgery and will be able to comply with rehabilitation requirements, including taking pain medication to enable post-surgery exercises to be undertaken.</p> <p>The NICE guideline on depression (CG23) 2007 recommends that screening should be undertaken in primary care and general hospital settings for depression in high-risk groups, for example, those with significant</p>	<p>NICE Clinical Guideline: <i>Depression</i> (CG23) 2007</p> <p>Rajiv Gandhi, J. Roderick Davey, And Nizar N. Mahomed Predicting Patient Dissatisfaction Following Joint Replacement Surgery <i>The Journal of Rheumatology</i> 2008; 36:12; <i>oi:10.3899/jrheum.080295</i></p>

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	physical illnesses causing disability. This advice will be taken into account in the development of GP referral guidelines which are being written to support primary care clinicians in the implementation of the policy.	
People with learning disabilities	<p>The threshold policies do not exclude patients with learning disabilities from surgery, but there is a requirement for surgeons to ensure appropriate consent from the patient and/or their carer; that the patient is fit for surgery, and will be able to comply with rehabilitation requirements, including taking pain medication to enable post-surgery exercises to be undertaken.</p> <p>The referral guideline (in development) will consider rehabilitation support for this patient group.</p>	See Threshold policies
Women who are pregnant or on maternity absence	Pregnancy is an exclusion criterion for elective hip and knee replacement surgery. The threshold policies do not exclude women on maternity absence from joint replacement surgery.	See Threshold policies
Single parent families	The threshold policies do not exclude or additionally disadvantage single parent families from joint replacement surgery.	See Threshold policies
People with different sexual orientations	The threshold policies do not exclude or additionally disadvantage people with different sexual orientation.	See Threshold policies
People with different work patterns (part-time, full-time, job-share, short-term)	<p>Access to hip and knee replacement surgery is not dependent on employment status.</p> <p>Hip and knee replacement surgery is associated with initiatives to minimise length of stay (Enhanced Recovery Programme).</p>	<p>NHS Institute for Innovation and Improvement www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/enhanced_recovery_programme.html</p>

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contractors, employed, unemployed)	Post-surgery rehabilitation might require a considerable period of time off work.	
People in deprived areas and people from different socio/economic groups	The threshold policies do not exclude or additionally disadvantage people from deprived areas or different socio/economic groups.	
Asylum seekers and refugees	<p>Asylum seekers and refugees need to be registered with GP/primary care services as an entry point to specialist surgery. Once assessed as appropriate for hip or knee replacement surgery in secondary care, access will not be affected by a patient's status as an asylum seeker or refugee.</p> <p>The Referral Guideline will signpost clinicians to the PCT's Health Advocate service who can support asylum seekers and refugees in gaining access to services.</p>	<p>http://opct.oxnet.nhs.uk/EqualityAndDiversity/Pages/EthnicityandL.aspx</p>
Prisoners and people confined to closed institutions, community offenders	Prisoners and those in closed institutions must have equal access to hip and knee replacement surgery. The prisons and closed institutions in Oxfordshire are currently supported by GPs in Buckinghamshire and Berkshire West but these contracts are currently out to tender. As soon as the providers are confirmed, direct contact will be made to ensure awareness of these local policies and how to access surgery for appropriate patients.	
Carers	<p>Supporting the rehabilitation of patients who have undergone hip and knee replacement surgery is likely to impose an additional burden on carers in the short term.</p> <p>However, long term outcomes should improve patients' ability to self care and independence.</p>	<p>After surgery patients</p> <ul style="list-style-type: none"> • Will have a large dressing over the incision. A small drainage tube may be placed during surgery to help drain blood that collects in the hip joint after surgery. • May have an IV catheter/tube) inserted into a vein for fluids until patient is able to drink on their own. • may have a catheter inserted into the bladder to drain urine. Usually it

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		<p>is removed 2 or 3 days after surgery.</p> <ul style="list-style-type: none"> • will need to wear special compression stockings to improve blood flow and reduce the risk of blood clots • most people will receive anticoagulant medicine to reduce the risk of blood clots • some patients may need to use a spirometer and do deep breathing and coughing exercises to help prevent pneumonia. • Will need to take analgesia for pain control. Some patients may need antibiotics to prevent infection. <p>Patients will be encouraged to start moving and walking on the first day after surgery. Some people need a short stay in a rehabilitation centre after they leave the hospital and before they go home.</p> <p>The results of hip replacement surgery are usually excellent. Most or all of patients' hip pain and stiffness should be resolved. However, some people may have problems with infection or loosening, or even dislocation, of the new hip joint. Full recovery will take from 2 to 3 months to a year.</p> <p>The outcomes of knee replacement surgery are more variable. Symptoms of pain should be resolved but movement may be limited, eg, kneeling may not be possible. http://www.nlm.nih.gov/medlineplus/ency/article/002975.htm</p>
Rural and/or isolated communities	The policy will not disadvantage rural and isolated communities in terms of access to hip and knee replacement surgery over and above the limitations already imposed by their home location.	
4. Have you identified any potential discrimination or adverse impact that cannot be	<p>Additional point. The NICE Clinical Guideline for Osteoarthritis (2008) reports evidence that people with a history of drug/alcohol abuse are less likely to be either referred for hip / knee replacement surgery, or to be listed for surgery.</p> <p>Whilst there may be clinical reasons for not operating in</p>	<p>NICE Clinical Guideline, 2008: <i>Osteoarthritis National clinical guideline for care and management in adults</i> [page 273]</p> <p>Anon (1995) NIH consensus conference: Total hip replacement. NIH Consensus Development Panel on Total Hip Replacement. <i>Journal of the American Medical Association</i> 273 (24): 1950–6.</p>

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<p>legally justified?</p> <p>If unsure, consult with the PCT Equality and Diversity Lead.</p>	<p>people who abuse drugs and/or alcohol, it is important that these patients are referred to appropriate services to address these health problems with a view to enabling them to undertake surgery in the future.</p> <p>These issues will be addressed in the referral guideline that is currently being developed to support implementation of the thresholds.</p>	<p>Coyte PC, Hawker Croxford GR, Croxford R et al. (1996) Variation in rheumatologists' and family physicians' perceptions of the indications for and outcomes of knee replacement surgery. <i>Journal of Rheumatology</i> 23 (4): 730–8.</p> <p>Mancuso CA, Ranawat CS, Esdaile JM et al. (1996) Indications for total hip and total knee arthroplasties. Results of orthopaedic surveys. <i>Journal of Arthroplasty</i> 11 (1): 34–46.</p>