NHS
Herefordshire and Worcestershire
Clinical Commissioning Group

Musculoskeletal Surgery and Therapeutic Interventions (non-Trauma)

October 2020

Commissioning Summary

Besides funding healthcare interventions that tackle ill health and save lives there is a growing demand for a range of orthopaedic procedures, some of which are considered to be lower priority when it comes to allocating limited NHS resources.

NHS Herefordshire & Worcestershire CCG (also termed “the Commissioner” in this document) recognise that in some cases the purpose of a low priority procedure will be to meet an appropriate and justifiable clinical need.

This policy provides commissioning statements regarding a number of interventions, which are split by anatomical site. These can be easily accessed via the Table of Contents.

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Document Details:

Version:	1.1
Ratified by (name and date of Committee):	Herefordshire & Worcestershire Clinical Commissioning Groups' - Joint Commissioning Committee – 25th February 2020 for use from 13th October 2020
Date issued:	October 2020
Internal Review Date:	Documents will be reviewed as a minimum every 3 years. However, earlier revisions to the policy may be made in light of published updates to local and national evidence of effectiveness and cost effectiveness and/or recommendations and guidelines from local, national and international clinical professional bodies. Date to Initiate Review: 13th October 2023
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Target audience:	Patients, GPs, Optometrists, Secondary Care and Primary Care (Community) Providers, Independent Sector Providers
Distribution:	GPs, Secondary Care & Primary Care (Community) Providers, Independent Sector Providers, CCG Internet Pages
Equality & Diversity Impact Assessment	February 2020

Key individuals involved in developing the document:

Name	Designation	Version Reviewed
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Circulated to the following individuals/groups for comments:

Name	Date	Version Reviewed
Policy Alignment Task & Finish Group	Various	V1.0
MSK Clinical Review Meeting (with specialists, GP representatives from both Worcestershire and Herefordshire)	14th February 2020	V1.0
Herefordshire & Worcestershire Clinical Commissioning Groups - Joint Commissioning Committee	Various – final review 25th February 2020	V1.0

Clinical Commissioning Policy Collaborative – minor points of clarification, agreed at appropriate governance level.	13th October 2020	V1.1

Version Control:

Version No	Type of Change	Date	Description of change
1.0	Significant	01/04/2020	Adaptation and adoption of policies from NHS Herefordshire Clinical Commissioning Group and NHS Worcestershire Clinical Commissioning Groups, following full alignment process and clinical review of policy statements that were not already fully aligned.
1.1	Minor	1/10/2020	Clarification of: - Arthroscopy of the Knee (therapeutic intervention) - Acupuncture commissioning arrangements

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1. Definitions

1.1 **Exceptional** - refers to a person who demonstrates characteristics, which are highly unusual, uncommon or rare.

1.2 **Exceptional clinical circumstances** are clinical circumstances pertaining to a particular patient, which can properly be described as exceptional, when compared to the clinical circumstances of other patients with the same clinical condition and at the same stage of development of that condition (i.e. similar patients). A patient with **exceptional clinical circumstances** will have clinical features or characteristics which differentiate that patient from other patients in that cohort and result in that patient being likely to obtain significantly greater clinical benefit (than those other patients) from the intervention for which funding is sought.

1.3 A **Similar Patient** is a patient who is likely to be in the same or similar clinical circumstances as the requesting patient and who could reasonably be expected to benefit from the requested treatment to the same or a similar degree. The existence of more than one similar patient indicates that a decision regarding the commissioning of a **service development** or commissioning policy is required of the Commissioner.

1.4 An **individual funding request (IFR)** is a request received from a provider or a patient with explicit support from a clinician, which seeks exceptional funding for a single identified patient for a specific treatment.

1.5 An **in-year service development** is any aspect of healthcare, other than one which is the subject of a successful individual funding request, which the Commissioner agrees to fund outside of the annual commissioning round. Such unplanned investment decisions should only be made in exceptional circumstances because, unless they can be funded through disinvestment, they will have to be funded as a result of either delaying or aborting other planned developments.

1. Scope of Policy

2.1 This policy is part of a suite of locally endorsed Commissioning Policies. Copies of these Commissioning Policies are available on the following website address: www.herefordshireandworcestershireccg.nhs.uk

2.2 This policy applies to all patients for whom Herefordshire & Worcestershire CCG has responsibility including:

- People provided with primary medical services by GP practices which are members of the CCG and
- People usually resident in the area covered by the CCG and not provided with primary medical services by any CCG.

2.3 The policy applies to:

- People with musculoskeletal symptoms (non-traumatic)
  Note: whilst the policy content and applicability does not cover trauma-related presentations, some local pathways referenced within this document may provide guidance on definitions of "trauma".
- All contracted service providers in secondary care or the community that offer orthopaedic services and interventions. Service providers must apply the criteria within this policy before carrying out the treatment.

2.4 Where a patient's clinical presentation does not clearly meet the requirements for secondary care management within the context of this policy, and where a GP is uncertain or concerned about the clinically appropriate treatment/management pathway, referral for Advice & Guidance should be considered as an alternative to a referral for clinical assessment.

2.5 There may be occasions when a GP referral is made for specialist assessment which appears to meet the policy requirements, but which on specialist clinical examination either does not meet the clinical criteria for surgery or is not considered clinically suitable for surgery. Such patients should be discharged without surgery.

2.6 Any referral for consideration of treatment/intervention should be made on the appropriate electronic referral form where this is available.

2.7 For patients who do not fall within the eligibility criteria set out in the policy but where there is demonstrable evidence that the patient has exceptional clinical circumstances, an Individual Funding Request may be submitted for consideration. The referring clinician should consult the Commissioner's "Operational Policy for Individual Funding Requests" document for further guidance on this process.

For a definition of the term "exceptional clinical circumstances", please refer to the Definitions section of this document.

2. Background

3.1 The NHS Constitution, which details the principles and values that guide the NHS, has been applied in the agreement of this policy.

3.2 NHS Herefordshire & Worcestershire Clinical Commissioning Group consider all lives of all patients whom they serve to be of equal value and, in making decisions about funding treatment for patients, will seek not to discriminate on the grounds of sex, age, sexual orientation, ethnicity, educational level, employment, marital status, religion or disability except where a difference in the treatment options made available to patients is directly related to a particular patient's clinical condition or is related to the anticipated benefits to be derived from a proposed form of treatment.

3.3 Musculoskeletal physiotherapy and advanced practitioner clinical assessment and treatment services are primary care/community based services that provide GPs with the opportunity to refer to an accessible, specialist diagnosis service, which also provides, where clinically appropriate, interventions for adults (age 18 and above) with symptomatic musculoskeletal conditions who require additional orthopaedic assessment and treatment.

3.4 The main aim of these services is to manage patients appropriately within primary and community based services avoiding unnecessary referrals to secondary care.

3. Relevant National Guidance and Facts

4.1 The National Institute for Health and Care Excellence have published a variety of guidance documents which have informed development of this policy including, but not limited to:

- Joint replacement (primary): hip, knee and shoulder [NG157] 04 June 2020
- Low back pain and sciatica in over 16s: assessment and management [NG59] Published: 30 November 2016 Last updated: 22 September 2020

4.2 NHS England/Improvement launched their Evidenced Based Interventions programme in 2018 which aims to ensure that interventions routinely available on the NHS are evidence-based and appropriate. The content of phase 1 guidance, which covers many of the areas contained within this document, became mandated in the NHS standard contract with effect from April 2019; but commissioners have the freedom to implement criteria with local variations, provided that the decision to adopt varying criteria reflects the requirement to have regard to the national guidance.

4.3 A Cochrane review suggests active educational interventions involving secondary care consultants and structured referral sheets are the only interventions proven to impact on referral rates. Structured referral sheets are checklists to be completed at the time of referral that prompt the GP about important elements of pre-referral investigation and management.

4.4 Guidance from the National Institute for Health and Care Excellence, NHS England and other authoritative bodies (eg. British Orthopaedic Association) has been used/considered in determining the recommendations and pathways within this policy. Recent policy updates now incorporate agreed primary care referral forms and use of recognised tools, where appropriate.

4. Patient Eligibility

5.1 **This policy applies to the following INTERVENTIONS:**

Ankle and Foot

Foot Treatments (including Bunions/Hallux Valgus/Hallux Rigidus)

OPCS-4.7 Codes: W151-154, W157, W441, W451, W591-594

Prior Approval (Blueteq) is required for secondary care interventions

Surgery is NOT routinely funded on the NHS for concerns about the appearance of feet alone.

Most patients with foot conditions and mild pain can be managed in primary care by providing patients with appropriate information on the conservative treatment options that can be used to help manage their symptoms such as:

1. Weight loss, where clinically appropriate,
2. Pain relief
3. Footwear modification (lower heels, wider fitting shoes, high toe box) and "over the counter" orthotics
4. Referral to Physiotherapy and Podiatry Services for consideration of specialist orthotics and gait analysis where necessary.

Surgery will be considered for NHS funding where:

1. All conservative treatment options (weight loss, pain relief, footwear modification, physiotherapy and orthotics) have failed over a minimum of 12 weeks
   AND
2. There is severe deformity (such as overriding toes) or severe pain
   AND
3. There is significant functional impairment preventing:
   - routine work or educational responsibilities or
   - routine domestic or carer activities

Note, this policy does not apply to:

- Patients who present with a skin ulcer thought to be caused by underlying deformity (or an imminent risk of an ulcer developing); these patients should be referred urgently regardless of any pain or functional impairment.
- Patients who have Diabetes Mellitus and a related foot problem.

Hands and Elbow

Carpal Tunnel Syndrome Surgery

OPCS-4.7 Codes: A651, A658, A659 and A692

Prior Approval (Blueteq) is required for secondary care interventions

The Commissioner WILL SUPPORT surgical intervention for patients in accordance with local management pathways. This can be summarised as follows:

1. Symptoms consistent with SEVERE disease, which can be defined as:
   - History of:
     - Persistent paraesthesia in the correct distribution AND
     - Persistent numbness and weakness in the correct distribution AND
     - Daily symptoms with frequent night waking
   - On Examination:
     - Reduced vibration and 2-point discrimination AND
     - Objective thenar muscle weakness AND
     - Thenar muscle wasting (visible)

OR

2. Symptoms consistent with MODERATE disease, which can be defined as:
   - History of:
     - Intermittent paraesthesia in the correct distribution (thumb, index, middle) AND
     - Exacerbation of symptoms at night AND
     - No persistent hypaesthesia
   - On Examination:
     - Objective sensory impairment in the correct examination AND
     - Objective weakness in the thumb/loss of coordination

   PROVIDING the patient has:
   a. Failed wrist splints (12 weeks assured use at night); AND
   b. Temporary improvement (< 6 weeks) following corticosteroid injection; OR No improvement following corticosteroid injection but positive (moderate or severe) nerve conduction; AND
   c. Symptoms significantly interfering with daily activities and sleep; AND
   d. Patient willing to proceed to surgery

NOTE: Nerve Conduction Studies are only indicated:

- In moderate disease following failure of wrist splints worn at night for 6-12 weeks and subsequent corticosteroid injection OR
- In severe disease, before surgery, where the diagnosis is in doubt

Rationale:

i. The agreed pathway seeks to minimise invasive surgery for patients who can be adequately managed with conservative treatments but ensures that patients in whom these measures fail receive timely referral and intervention where appropriate.

ii. National guidance, formulated jointly between NHS England and the British Society for Surgery of the Hand, supports the pathway approach to conservative management of patients with mild and moderate symptoms and there is no evidence that the timescales within the pathway will adversely influence outcomes

NHS England EBI Policy states that: "Mild cases with intermittent symptoms causing little or no interference with sleep or activities require no surgical treatment

Dupuytren's Contracture

OPCS Codes: T521, T522, T525, T526, T528, T529, T541, T549, T561, T562

Prior Approval (Blueteq) is required for secondary care interventions

Dupuytren's disease is a benign painless condition that develops over time. Not all patients develop a contracture. Approximately 50% of patients with an isolated nodule will go on to develop a cord, of whom 9% will progress to meet criteria for surgery. The normal progression of the disease means that it could be between 5 and 10 years before a patient's disease has reached the stage at which clinical intervention is considered clinically appropriate.

The British Society for Surgery of the Hand (BSSH) have classified Dupuytren's disease and this together with the recommended action for management should be followed in Herefordshire and Worcestershire:

Classification and Primary Care Management of Dupuytren's Disease		
Severity	**Description**	**Action**
Mild	No functional problems No contracture (there may be nodules) Mild MCP or PIP joint contracture < 30°	Watchful Waiting (There are no effective conservative measures)
Moderate	Functional problems AND MCP joint contracture 30° to 60° +/- PIP joint contracture +/- First web contracture	Referral to specialist hand surgeon when functional problems become significant.
Severe	MCP contracture > 60° AND PIP contracture > 30°	Referral to specialist hand surgeon

The Commissioner WILL SUPPORT the following treatment options:

Treatment Modality	**Eligible patients:**
Needle Fasciotomy (where considered safe and appropriate)	• Primary disease in up to 2 joints AND • 30° ≤ MCP ≤ 60° AND • PIP < 30° **OR** 1st web contracture AND • Administration in an Out-Patient setting
Fasciectomy Palmar (segmental) or Digital (regional/selective) depending on circumstances)	Moderate to severe disease as defined above with functional problems and: • Single joint involvement on one digit - contractures > 30° or • Multiple joint involvement on one digit – contracture > 50° total
Dermofasciectomy	Aggressive/extensive disease with functional problems and: • Single joint involvement on one digit - contractures > 40° or • Multiple joint involvement on one digit – contracture > 60° total OR Severe recurrent disease following prior surgical intervention

Rationale:

i. Local resources are limited and therefore priority is given to patients with greatest need

ii. Contractures left untreated usually progress and often fail to strengthen fully with any treatment if allowed to progress too far. Complications causing loss, rather than

improvement, in hand function occur more commonly after larger interventions, but larger interventions carry a lower risk of need for further surgery

iii. This guidance correlates with national guidance formulated jointly between NHS England and the British Society for Surgery of the Hand

Ganglion Surgery

OPCS-4.7 Codes: T591-599

Prior Approval (Blueteq) is required for secondary care interventions

The Commissioner WILL SUPPORT surgical intervention for patients in accordance with the following management pathways:

Wrist ganglia causing pain or tingling/numbness

1. Consider watchful waiting
2. Aspiration (in primary care) if causing significant pain, tingling/numbness or concern (worried it is a cancer);
3. Surgical excision only considered if aspiration fails to resolve the pain or tingling/numbness and there is restricted hand function causing functional impairment.

Note: Surgery is not commissioned for wrist ganglia that do not meet this criterion

Seed ganglia that are painful

1. Puncture/aspirate (in primary care) the ganglion using a hypodermic needle, where clinically appropriate
2. Surgical excision only considered if ganglion persists or recurs after puncture/aspiration and there is functional impairment

Note: Surgery is not commissioned for seed ganglia that do not meet this criterion

Mucous cysts

- Consider surgery if recurrent spontaneous discharge of fluid or significant nail deformity.

Note: Surgical excision is not commissioned for mucous cysts that do not meet this criterion

Rationale:

i. Most wrist ganglia get better on their own. Surgery causes restricted wrist and hand function for 4-6 weeks, may leave an unsightly scar and be complicated by recurrent ganglion formation. Aspiration of wrist ganglia may relieve pain and restore hand function, and "cure" a minority (30%). Most ganglia reform after aspiration but they may then be painless. Aspiration also reassures the patient that the swelling is not a cancer but a benign cyst full of jelly.

ii. Local resources are limited and therefore priority is given to patients likely to benefit most.

This guidance correlates with national guidance formulated jointly between NHS England and the British Society for Surgery of the Hand.

Trigger Finger Surgery

OPCS-4.7 Codes: T711, T723, T744

Prior Approval (Blueteq) is required for secondary care interventions

Cases interfering with activities or causing pain should first be treated in primary care with:

a. One or two steroid injections which are typically successful (strong evidence), but the problem may recur, especially in people who have diabetes;
   OR
b. Splinting of the affected finger for 3-12 weeks (weak evidence).

Referral for consideration of surgery should only be considered if:

a. The triggering persists or recurs after one of the above measures (particularly steroid injections);
   OR
b. The finger is permanently locked in the palm;
   OR
c. People who have diabetes.

Note: Surgery is not commissioned outside of these indications

Rationale:

i. Mild cases which cause no loss of function require no treatment or avoidance of activities which precipitate triggering and may resolve spontaneously.

ii. Treatment with steroid injections usually resolve troublesome trigger fingers within 1 week (strong evidence) but sometimes the triggering keeps recurring.

This guidance correlates with national guidance formulated jointly between NHS England and the British Society for Surgery of the Hand.

Hip

Hip Replacement Surgery (THR)

OPCS-4.7 Codes: Primary - W371 Cement; W381 Uncemented, W391 Unspecified

Prior Approval (Blueteq) is required for this intervention.

The Commissioner **WILL ONLY SUPPORT** joint replacement surgery for patients who have:

1. **Failed conservative measures** in primary care to alleviate the patient's pain and disability; each treatment should be attempted for 12 weeks (where clinically appropriate) to determine efficacy. These should include:
   - Advice and engagement in weight loss and exercise
   - Analgesics up to Step 3, NSAIDs
   - Physiotherapy
   - Use of recommended walking aids, home adaptation
   - Engagement in modified behaviour to reduce aggravating the condition

   AND
2. An **Oxford Hip Score (OHS) of less than 30** (e.g. patient's pain and disability should be sufficiently severe that it interferes with the patient's daily life and/or ability to sleep).

   AND
3. A **BMI of below 35** supported by a primary care and/or community MSK service referral;

   AND
4. Following provision of information regarding the potential risks and benefits of joint replacement, the **patient would accept surgery and is considered fit for surgery**.

NOTE: It is recognised that patients with severe hip arthritis proven on a reported radiograph may be unable to undertake all of these measures as physiotherapy may offer limited benefit for this patient group.

Patients Not Meeting Clinical Eligibility Criteria for Surgery:

Where a patient's BMI is above 35, the Commissioner **will consider** joint replacement surgery ONLY if there is evidence the patient has:

- **Mobility** so compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this threat.

OR

- **Joint destruction** of such severity that delaying surgical correction would increase the technical difficulty of the procedure if delayed.

OR

- **Engaged actively with a weight management programme** and achieved a 10% reduction in their weight.

Rationale:

Local resources are limited and therefore priority is given to patients with greatest need. This determination has been undertaken following a review of the evidence and consideration of the local circumstances for use.

Failed Conservative Measures: *Royal College of Surgeons guidance.*

OHS: *There are no validated tools that assess which patients are either most in need of surgery or who would benefit most from surgery. However, the OHS is a validated patient-reported measure with which disease burden and impact on a patient's quality of life can be*

measured. It is evident that the level of health gain from surgery is greatest for those patients with lower pre-operative OHS, which has guided the threshold for referral and intervention. ***BMI:*** *To maximise the chances of the most beneficial patient outcomes, referring clinicians should actively engage patients with a BMI of 35 or more into existing weight management pathways. Surgery on patients with a BMI of less than 35 will maximise the functional benefit of surgery and reduce the risk of complications during and/or following surgery. There is evidence of compromised surgical success in patients who are morbidly obese (BMI >40) and super obese (BMI >50) arising from complication profiles that may outweigh the functional benefits of total joint arthroplasty.*

Further details of the Oxford Hip Scoring Tool can be found at the following website addresses: http://www.orthopaedicscore.com/scorepages/oxford_hip_score.html

Therapeutic Arthroscopic Hip Procedures

for hip impingement syndrome, labral tear and other hip pathologies

The Commissioner **DOES NOT ROUTINELY SUPPORT** the funding of therapeutic arthroscopic hip procedures – for hip impingement syndrome, labral tear and other hip pathologies.

Rationale:
This decision was made based on a full evidence review, updated in January 2019; this included a review of the current NICE Interventional Procedure Guidance relating to this procedure in hip impingement syndrome IPG 408, a Cochrane review published in 2014, a review undertaken by Solutions for Public Health October 2017 and a further review of evidence to December 2018. Further details on this can be found in Appendix A.

Hip Resurfacing

UNDER REVIEW

Knee

Arthroscopy of the Knee (non-Trauma*)

* including incidents that occur during routine activities

Diagnostic Arthroscopy

OPCS code: W879

An IFR application with clear evidence of clinical exceptionality is required for consideration of NHS funding.

The Commissioner **DOES NOT ROUTINELY SUPPORT** the funding of diagnostic arthroscopy.

Rationale:
A clinical examination (history and examination) by a competent clinician will give a diagnosis and demonstrate if internal joint derangement is present. If there is diagnostic uncertainty despite competent examination, then an MRI scan might be indicated (see above); this decision should be made by secondary care specialists. MRI is rarely necessary but when appropriate, is a less invasive diagnostic procedure for the investigation of knee pain.

Pre-operative Assessment Knee Arthroscopy

Prior Approval (Blueteq) is required for this intervention.

The Commissioner **WILL SUPPORT** the funding of arthroscopy as part of pre-operative assessment prior to definitive surgery.

Rationale:
For a small number of patients, a pre-operative arthroscopy may be considered necessary to determine the nature of surgery to be undertaken ie. high tibial osteotomy, uni-compartmental or total knee replacement.

Debridement and Lavage

OPCS Codes: W802, W808

An IFR application with clear evidence of clinical exceptionality is required for consideration of NHS funding.

The Commissioner **DOES NOT ROUTINELY SUPPORT** the funding of arthroscopic debridement and/or lavage.

Rationale:
The evidence has consistently demonstrated that in patients with osteoarthritis debridement +/- lavage has little, if any, effect on short-term outcomes, satisfaction, or pain compared to non-operative treatment. The evidence of benefit for younger patients is weak.

Therapeutic Intervention (including repair and resection)

OPCS Codes: W822, W823

Prior Approval (Blueteq) is required for this intervention.

Referral of patients with symptomatic knee pain is supported when:

1. Red flags necessitating URGENT referral
   - *Suspicion of septic arthritis, osteonecrosis or slipped capital femoral epiphysis*
   - *Fracture cannot be excluded*
   - *Severe soft tissue injury with gross instability*

   OR
2. True mechanical symptoms
   Defined as either:
   - *Knee giving way daily or near daily (≥ 4/7) for at least 1 month OR*
   - *Episodes of locking in FLEXION (true locking)*

   OR
3. Failure of non-operative interventions over 6 months without significant functional improvement WITH **no** evidence of osteoarthritis

The Commissioner WILL ONLY SUPPORT the funding of arthroscopic intervention, when there is no evidence of osteoarthritis (radiographic features, signs or symptoms) and one of the following:

- Meniscal fragment in tibial gutter OR
- Parameniscal cyst OR
- Patellofemoral (restricted) osteoarthritis with recurrent swelling OR
- True mechanical symptoms (as defined above)

Where available, local pathways for management of Symptomatic Knee Pain should be followed.

Rationale *(supported by various authoritative bodies/guidelines)**:***

i. Red flags may be indicative of more sinister pathology and require specialist review and evaluation.

ii. The evidence to support intervention in patients with mechanical symptoms is inconsistent and poor, therefore intervention should only be considered in severe circumstances as defined on the pathway.

iii. There is overwhelming evidence demonstrating that conservative management produces comparable results to arthroscopic intervention in patients with degenerative knee pathology.

iv. There is evidence that arthroscopic intervention in patients with evidence of osteoarthritis may worsen/increase the risk of symptomatic knee osteoarthritis.

v. Evidence indicative of osteoarthritis (OA):
Radiographic reporting features indicative of OA - including osteophytes, joint space narrowing, degenerative joint disease (DJD)
Age 45 years of age or more with symptoms & signs clearly suggesting OA (NICE 2015):
- *Affected joints are painful when used (+/- pain at rest, crepitus, limited range movement)*
- *Affected joints become stiff after resting*

Knee Replacement Surgery (TKR)

OCPS-4.7 codes: Primary - W401 Cemented - W411 Uncemented - W421 Unspecified

Prior Approval (Blueteq) is required for this intervention.

The Commissioner **WILL ONLY SUPPORT** joint replacement surgery for patients who have:

1. **Failed conservative measures** in primary care to alleviate the patient's pain and disability; each treatment should be attempted for 12 weeks (where clinically appropriate) to determine efficacy. These should include:
   - Advice and engagement in weight loss and exercise
   - Analgesics up to Step 3, NSAIDs
   - Physiotherapy
   - Use of recommended walking aids, home adaptation
   - Engagement in modified behaviour to reduce aggravating the condition

   AND
2. **An Oxford Knee Score** (OKS) of less than 30 (e.g. patient's pain and disability should be sufficiently severe that it interferes with the patient's daily life and/or ability to sleep).

   AND
3. A **BMI of below 35** supported by a primary care and/or community MSK service referral;

   AND
4. Following provision of information regarding the potential risks and benefits of joint replacement, the **patient would accept surgery and is considered fit for surgery**.

NOTE: It is recognised that patients with severe knee arthritis proven on a reported radiograph may be unable to undertake all these measures as physiotherapy may offer limited benefit for this patient group.

Patients Not Meeting Clinical Eligibility Criteria for Surgery:

Where a patient's BMI is above 35, the Commissioner will consider joint replacement surgery ONLY if there is evidence the patient has:

- Mobility so compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this threat.

OR

- Joint destruction of such severity that delaying surgical correction would increase the technical difficulty of the procedure if delayed.

OR

- Engaged actively with a weight management programme and achieved a 10% reduction in their weight.

Rationale:

Local resources are limited and therefore priority is given to patients with greatest need. This determination has been undertaken following a review of the evidence and consideration of the local circumstances for use.

Failed Conservative Measures: *Royal College of Surgeons guidance.*

OKS: *There are no validated tools that assess which patients are either most in need of surgery or who would benefit most from surgery. However, the OKS is a validated patient-reported measure with which disease burden and impact on a patient's quality of life can be measured. It is evident that the level of health gain from surgery is greatest for those patients with lower pre-operative OKS, which has guided the threshold for referral and intervention.*

BMI*: To maximise the chances of the most beneficial patient outcomes, referring clinicians should actively engage patients with a BMI of 35 or more into existing weight management*

pathways. Surgery on patients with a BMI of less than 35 will maximise the functional benefit of surgery and reduce the risk of complications during and/or following surgery. There is evidence of compromised surgical success in patients who are morbidly obese (BMI >40) and super obese (BMI >50) arising from complication profiles that may outweigh the functional benefits of total joint arthroplasty.

Further details of the Oxford Knee Scoring Tool can be found at the following website addresses: http://www.orthopaedicscore.com/scorepages/oxford_knee_score.html

Intra-articular Hyaluronic acid for OA of the Knee

(including Synvisc-One®)

The Commissioner **DOES NOT ROUTINELY SUPPORT** funding of this intervention, for any joint, due to lack of evidence of clinical efficacy.

Rationale:
The Medicines and Prescribing Committee (MPC) has reviewed the evidence for, and use of, these products; the evidence is limited and weak. NICE Clinical Guideline CG177 Osteoarthritis: Care and Management states "Do not offer intra-articular hyaluronan injections for the management of osteoarthritis".

Miscellaneous

Acupuncture and Electrotherapy

Acupuncture:

UNDER REVIEW

No change to current commissioning pathways.

Trans-cutaneous electrical nerve stimulation is not commissioned as a stand-alone service from either NHS or independent sector providers. It may be offered by physiotherapists as an adjunct to core treatments for short-term pain relief (up to 10 weeks) only in patients with osteoarthritis.

Electro-acupuncture is not supported due to lack of robust evidence of clinical efficacy.

Interferential therapy is not supported due to lack of evidence of clinical benefit to support a recommendation for the use of interferential therapy as a treatment for low back pain or sciatica. Until such time as a more comprehensive review is undertaken, interferential therapy is not supported for any other indication.

Exogen Therapy for Non-Union Fractures of Long Bones

The Commissioner **WILL SEPARATELY FUND**:

- use of Exogen® ultrasound bone healing system to treat long bone fractures with non-union, in accordance with defined clinical and process criteria (see page 11 of the separate Exogen Policy, accessed using the link below)

The Commissioner **WILL NOT SEPARATELY FUND**:

- use of Exogen® ultrasound bone healing system to treat long bone fractures with delayed union
- any other indications for use of Exogen® ultrasound bone healing system

Please refer to the separate CCG policy on this treatment:
Exogen Therapy Commissioning Policy April 2020

Rationale:
Local resources are limited and therefore priority is given to patients with greatest need. This determination has been undertaken following a review of the evidence and consideration of the local circumstances for use.

Therapeutic Ultrasound in Physiotherapy

The Commissioner **DOES NOT ROUTINELY SUPPORT** the NHS funding of this treatment due to lack of evidence of clinical efficacy.

Prolotherapy ("proliferation therapy" or "regenerative injection therapy") and Platelet Rich Plasma Injections

The Commissioner **DOES NOT ROUTINELY SUPPORT** the NHS funding of these interventions across all indications, an IFR application based on exceptional clinical circumstances may be considered.

Rationale:
There is a lack of good quality evidence supporting the clinical effectiveness or cost-effectiveness for these interventions across all indications.

Shoulder

Shoulder Surgery

including excision of acromio-clavicular joint, subacromial decompression and rotator cuff tear repair

Prior Approval (Blueteq) is required for this intervention.

The Commissioner WILL SUPPORT surgical intervention for patients in accordance with local management pathways. This requires that patients have:

1. Failed 1st line Conservative management over a period of 4-6 weeks

AND

2. Been compliant with Physiotherapy over a 4-6 week period

AND

3. Failed to respond or responded and symptoms have returned to Corticosteroid injection (whilst compliant with conservative management & physiotherapy), unless clinically inappropriate

AND

4. Symptoms remain intrusive and debilitating despite the above and following review by a musculoskeletal practitioner

Rationale:

The agreed pathway seeks to minimise invasive surgery for patients who can be adequately managed with conservative treatments but ensures that patients in whom these measures fail receive timely referral and intervention where appropriate.

Spine

Spinal Diagnostics Pathway

If the patient has signs and symptoms associated with the following red or amber flags patients should be referred, using the appropriate pathway. All other patients should be managed in accordance with the recommendations for spine diagnostics below.

RED FLAGS – immediate referral recommended – expected intervention within 24 hours

- **Acute Cauda Equina Syndrome** – refer to **specialist spinal provider**
- **Suspected Spinal Cord Neurology** – refer to **specialist spinal provider**
  Gait disturbance, multilevel weakness in the legs ± arms, major motor radiculopathy
- **Metastatic Spinal Cord Compression (MSCC)** –Urgent referral to:
  - Worcestershire Patients – contact the MSCC coordinator (Acute Oncology Service (AOS) Nurse Monday to Friday, 9.00am – 5.00pm, obtainable on Bleep 398/ 491 or the Oncology Consultant on-call out of hours via WAHT switchboard, Tel. 01905 763333)
  - Herefordshire Patients – contact the MSCC coordinator via Orthopaedics at Gloucestershire Hospitals NHS Foundation Trust

AMBER FLAGS – urgent referral – expected intervention with 1-2 weeks

- **Osteoporotic Spinal Fracture with Severe Pain ± Neurological Signs** – refer to **specialist spinal provider**
- **Suspected Metastases** – refer within 24 hours to **MSCC coordinator** (as above)

Rationale:
The NICE pathway for management of suspected metastases or MSCC is clear that all patients should be referred to the MSCC coordinator within 24 hours; the MSCC coordinator will be responsible for determining appropriate investigations and management within a timely manner depending on the presenting circumstances.

NICE Guideline CG75 Metastatic spinal cord compression in adults: risk assessment, diagnosis and management (2008)
NICE Pathway Metastatic spinal cord compression overview (October 2017)

For management of low back pain and sciatica, NICE Guideline 59 recommends:

1. Consideration of alternative diagnosis
2. Risk stratification using for example STarT Back tool for each new episode of low back pain with or without sciatica
3. Non-Invasive self-management involving education, exercise and manual therapy as part of a treatment package including exercise with or without psychological therapy.
4. Appropriate pharmacological interventions (see https://www.nice.org.uk/guidance/ng59) in consideration with Herefordshire & Worcestershire Joint Medicines Formulary https://www.hereworcsformulary.nhs.uk/ and Herefordshire & Worcestershire Medicines and Prescribing Committee guidance, which can be accessed here: https://herefordshireandworcestershireccg.nhs.uk/policies/medical/clinical-policies-guidance
5. Promote and facilitate return to work or normal activities of daily living.

6. **Do not offer** traction, belts, corsets, foot orthotics, rocker sole shoes, acupuncture (including PENS and TENS), ultrasound or interferential therapy.

Disc Replacement Surgery

The Commissioner **DOES NOT ROUTINELY SUPPORT** the funding of disc replacement surgery

Rationale: *NICE Guidance (NG 59) identifies that there is limited evidence of effectiveness alongside concerns in relation to long-term outcomes and potential for harm, and thus conclude that disc replacement surgery is not recommended in people with low back pain with/without sciatica.*

Facet Joint Injections (FJI)

OPCS-4.7 Code: V544

The Commissioner **DOES NOT ROUTINELY SUPPORT** the funding of facet joint injections.

Rationale*:*

1. *NICE Guidance (NG59) states that Facet Joint Injections (FJI) should not be offered, in accordance with evidence of best practice and guidance of limited effectiveness.*
2. *The National Back Pain Pathway (Greenough, 2017) and NHS England EBI (December 2018) concur with this and recommends that FJI are not offered. The NHS England EBI guidance is approved by the British Association of Spinal Surgeons.*

Radiofrequency Denervation

(dorsal rhizotomy and radiofrequency ablation)

Prior Approval (Blueteq) is required for this intervention.

The Commissioner WILL SUPPORT a single treatment with radiofrequency denervation for chronic pain (> 2 years) when:

- Non-surgical treatment has failed
  AND
- The pain originates from structures supplied by the medial branch nerve (evidenced by a positive response to a diagnostic medial branch block)
  AND
- Localised back pain is moderate to severe (> 5 on VAS)

Repeat treatments with radiofrequency denervation are not routinely commissioned

Notes:

1. Imaging for people with specific facet joint pain is not a prerequisite for radiofrequency denervation
2. Patients who experienced prolonged pain relief from medial branch blocks (i.e. an analgesic effect outlasting the expected duration of local anaesthesia) should be offered radiofrequency denervation rather than repeated medial branch blocks

Rationale:

i. NICE Guidance (NG59) identifies that these criteria are consistent with the population of patients involved in the trials that demonstrate efficacy for radiofrequency denervation.

ii. The evidence for use of repeat treatment with radiofrequency denervation is limited, the duration of benefit and cost-effectiveness is unclear. NICE identify this as an area for further research.

Spinal Decompression

The Commissioner **WILL SUPPORT** spinal decompression for people with sciatica when:

- Non-surgical treatment has not improved pain or function (including a single spinal epidural injection where appropriate)
  AND
- Radiological findings are consistent with sciatic symptoms

Rationale: *NICE Guidance (NG59) identifies that that sciatic symptoms usually improve over the course of the first 3 months in the majority of people without treatment. Further evidence identifies that 50% of people who have an epidural do not go on to have surgery. Beyond this, discectomy for people suffering from sciatica offers a good prognosis and is successful in providing long-term pain relief for the subgroup of people who have failed to respond to conservative management.*

Spinal Epidural Injections (SEI)

OPCS-4.7 Codes: A521, A522

Prior Approval (Blueteq) is required for this intervention.

The Commissioner **WILL SUPPORT a single SEI** of local anaesthetic and steroid in the following circumstances:

- For severe, non-controllable radicular pain in prolapsed intervertebral disc early in the clinical course for symptom control
- For treatment of lumbar radicular pain with the aim of avoiding surgery

Repeat SEI are not routinely commissioned

SEI are NOT ROUTINELY SUPPORT for patients with neurogenic claudication in people who have central spinal canal stenosis.

For people with non-specific low back pain the following injections should not be offered:

- Facet joint injections (see separate policy statement)
- Therapeutic medial branch blocks
- Intradiscal therapy (including, but not limited to, electrothermal ablation, thermal annuloplasty, electrothermal treatment and percutaneous electrothermal treatment)
- Prolotherapy
- Trigger point injections with any agent, including botulinum toxin
- Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spinal canal stenosis
- Any other spinal injections not specifically covered above

Rationale*:*

i. The national back pain pathway states that the utility of diagnostic lumbar nerve root injections has not been fully established and they should not be used for neurogenic claudication with central spinal stenosis.

ii. *NICE Guidance (NG59) recommends use to avoid surgery as stated above. NICE considered that as the indication is for an acute sciatica population, then multiple injections would not usually be performed.*
iii. *NHS England EBI (December 2018) concur and this is approved by the British Association of Spinal Surgeons.*

Spinal Fusion Surgery

OPCS-4.7 Codes: V371-379, V381-389

The Commissioner **DOES NOT ROUTINELY SUPPORT** the funding of spinal fusion surgery for patients with low back pain.

Rationale:
NICE Guidance (NG 59) identifies that there is a lack of evidence of clinical effectiveness to recommend spinal fusion for people with low back pain other than in the context of a randomised controlled trial.

5. Supporting Documents

- NHS Herefordshire & Worcestershire: Individual Funding Request Operating Procedure
- NHS Herefordshire & Worcestershire: Prioritisation Framework for the Commissioning of Healthcare Services
- WM01 – Ethical Framework
- WM02 – Orphan Drugs
- WM03 – Patients Leaving Industry Sponsored Trials
- WM05 – NICE Guidance
- WM07 – Choice
- WM08 – In Year Service Developments
- WM09 – Individual Funding Requests (to be read with local process document)
- WM10 – Patients Leaving Non Commercially Funded Trials
- WM11 – Patients Leaving a CCG Funded Trial
- WM12 – Patients Changing Responsible Commissioner
- WM13 – NHS Private Interface
- WM14 – Experimental Treatments
- WM15 – Trial of Treatment
- NHS Constitution, updated 27th July 2015
- Stoke on Trent Primary Care Trust and NHS North Staffordshire – Acute Service – Exclusions and Prior Approvals Guidelines 2008/9
- NHS Warwickshire Commissioning Policy: Treatments considered Low Priority
- Bristol North, Bristol South & West and South Gloucestershire Primary Care Trusts - Commissioning services for people with orthopaedic problems August 2006
- West Sussex Primary Care Trust – Commissioning for Clinical Effectiveness Procedures where Thresholds Apply August 2007
- Coventry & Rugby Clinical Commissioning Group policy
- Northern, Eastern and Western Devon Clinical Commissioning Group policy
- Is Access To Surgery A Postcode Lottery? The Royal College of Surgeons of England (Hip Replacement Section) – July 2014

- NICE Guidance (NG59): Low back pain and sciatica in over 16s: assessment and management, published November 2016
- Worcestershire Clinical Commissioning Policy Collaborative: Specific evidence reviews in relation to clinical areas
- NHS England: Evidenced Based Interventions (December 2018)

6. Appendices

Appendix A

Therapeutic arthroscopic hip procedures – for hip impingement syndrome, labral tear and other hip pathologies	The Commissioner **DOES NOT SUPPORT** the funding of this intervention. Requests on an exception basis should be made by the treating clinician through the Individual Funding Request route. **Rationale:** This decision was made based on a full evidence review, updated in January 2019; this included a review of the current NICE Interventional Procedure Guidance relating to this procedure in hip impingement syndrome IPG 408, a Cochrane review published in 2014, a review undertaken by Solutions for Public Health October 2017 and a further review of evidence to December 2018. ➢ NICE IPG 408 concluded that current evidence on the efficacy of arthroscopic femoro–acetabular surgery for hip impingement syndrome is adequate in terms of symptom relief only in the short to medium term. Therefore, this procedure should only be used where arrangements are in place for clinical governance, consent and proper audit with local review of outcomes. IPG 408 does not specifically endorse hip arthroscopy on the grounds of cost-effectiveness. ➢ A Cochrane review of evidence in 2014 on the efficacy of arthroscopy for FAI identified similar issues to those in NICE IPG 408, especially with regards to the poor of quality evidence. ➢ Evidence to date only provides short term outcomes from the intervention and the evidence for longevity of the procedure is therefore limited. ➢ Four RCTs (Randomised Control Trials) were in progress when the Worcestershire evidence review was undertaken in 2015. Since then 2 RCTs have been published with conflicting outcomes; both trials compared arthroscopic intervention with conservative management. The trial involving 80 patients did not demonstrate any significant difference in outcomes at any time over a 2 year period. The other trial demonstrated improved outcomes for arthroscopic intervention at 12 months but not at 6 months; the relevance of clinical improvement is unclear and it was determined that conservative management is more cost-effective. A third UK RCT is “in publication” but the outcomes are unknown. 2 further RCTs remain in progress. ➢ The RCT evidence compares the arthroscopic procedure to conservative management, but there are no published RCTs comparing the arthroscopic intervention with open surgery. Although there is accumulating evidence for the use of hip arthroscopy for femoro-acetabular impingement and for labral pathology, this has not been considered by NICE and is insufficient to make an informed recommendation. IPG 408 suggests arthroscopy may delay the progression to osteoarthritis however there is only limited epidemiological evidence for this association, and there is no direct evidence suggesting arthroscopy prevents future hip replacements. This association may only be determined through further long term trials and regular evidence reviews.

7. Equality Impact Assessment

Organisation	NHS Herefordshire & Worcestershire Clinical Commissioning Groups		
Department	Contracts & Policy Development	Name of lead person	Fiona Bates & Helen Bryant
Piece of work being assessed	Musculoskeletal Surgery and Therapeutic Interventions Policy		
Aims of this piece of work	Revise to include changes made to the previous guidelines for patients and for clinicians in both primary and secondary care on the medical/clinical requirements against which musculoskeletal procedures/interventions will be funded on the NHS within Herefordshire & Worcestershire.		
Date of EIA	February 2020	Other partners/stakeholders involved	Herefordshire & Worcestershire Policy Alignment Task & Finish Group
Who will be affected by this piece of work?	Individuals with musculoskeletal problems requiring further investigation and possible interventions as part of an NHS pathway of care		

Clinical Area → / Equality Strand ↓	Bunions and hallux valgus	Carpal Tunnel Syndrome	Dupuytren's Contracture	Trigger Finger Surgery	Hip Replacement Surgery	Knee Replacement Surgery
Gender	More prevalent in women than men.	More prevalent in women but variability between studies	More aggressive form of disease prevalent in Caucasian males < 50	More common among women than men in the fifth or sixth decade of life.	Various studies suggest that the rates are higher in women than men but suggest that this may be linked to higher rates of obesity.	
Race	No issue	Whites have the highest risk of developing CTS. The syndrome appears to be very rare in some racial groups (eg, nonwhite South Africans).	More aggressive form of disease prevalent in Caucasian males < 50	Prevalence higher among patients with diabetes mellitus, rheumatoid arthritis, or conditions that cause systemic deposition of protein such as amyloidosis. Some of these conditions are influenced by race	Caucasians have the highest annual age-standardized rates Blacks, Japanese, Hispanics, Chinese and Filipino have lower rates in decreasing order compared to Caucasians.	Caucasians have higher rates than African-Americans. Rates are around a third lower among blacks. The ethnic/racial disparity appears lower among women (23% and 28%) than among men (63% and 60%).
Disability	No issue	The nature of the disease may disadvantage patients with a disability. However, policy provides guidance on optimal treatments at key stages of disease pathway.			No issue	No issue
Religion/ belief	No issue	No issue	No issue	No issue	No issue	No issue
Sexual orientation	No issue	No issue	No issue	No issue	No issue	No issue
Age	Prevalence 23% in adults aged 18 to 65 years. It becomes more frequent with increasing age.	Peak age range for development is 45-60 years. Only 10% of patients are younger than 31 years.	More common in men aged over 50 and women aged over 60. More aggressive form of disease prevalent in Caucasian males < 50	2 % in the general population, and more common among women than men in the fifth or sixth decade of life	Osteoarthritis, a disease of age, is the commonest underlying condition for both TKA and THA. Other conditions leading to TKA and THA include inflammatory arthritis, fracture, dysplasia, malignancy	
Social deprivation	Rare in unshod populations but associates with wearing high-heeled or narrow shoes	Higher incidence in overweight patients.	No issue	No issue	No issue	No issue
Carers	No issue	Some evidence that CTS may be more common in people who use hands for strenuous, repetitive tasks and in those making extensive use of vibrating tools.	The nature of the disease may disadvantage carers in undertaking their role.	No issue	The nature of the disease may disadvantage carers in undertaking their role.	
Human rights	No issue	No issue	No issue	No issue	No issue	No issue
SUMMARY: differential impact?	No differential impact for any aspect in terms of policy delivery as the decision to treat a patient will be made on clinical presentation rather than on the patient's alignment with any of the protected characteristics.					

Clinical Area → / Equality Strand ↓	Therapeutic arthroscopic procedures: hip impingement syndrome, labral tear and other hip pathologies.	Knee Arthroscopy: - Diagnostic - Pre-operative - Debridement and Lavage - Therapeutic intervention		Intra-articular Hyaluronic Acid Injections for Osteoarthritis	Joint Injections (including Corticosteroid)	Exogen Therapy for Non Union Fractures of Long Bones	Low Back Pain (including sciatica)
Gender	There is evidence to support a higher prevalence in high level athletics during adolescence eg. football, soccer, ice hockey, which are, traditionally, more male orientated sports.	Where there is evidence of OA this may be more prevalent in females. However, there is evidence that meniscal tears are more prevalent in older men than women; meniscal destruction is more equivocal except in the 70-90 year age group where it is significantly more prevalent in females.		Females have a higher prevalence and more severe OA.		See separate policy for completed EIA.	Patient.co.uk a higher prevalence of low back pain in women due to changes in posture associated with adolescence and pregnancy
Race	There is insufficient evidence to support a genetic cause	No issue	No issue	Hip & hand OA is reported less frequently among the Chinese population than in the white population, however, Chinese women have significantly higher prevalence of both radiographic and symptomatic knee OA than white women. Prevalence of hip OA in African American women (23%) was similar to that in white women (22%), and prevalence was slightly higher in African American men (21%) than that in white men (17%).			NICE note that more Western European people report this issue.
Disability	No issue	No issue	No issue	The nature of the disease may impact more on those with disabilities.			No issue
Religion/ belief	No issue	No issue	No issue	No issue	No issue		No issue
Sexual orientation	No issue	No issue	No issue	No issue	No issue		No issue
Age	Mainly affects young and middle-aged adults.	Likely to be more relevant to younger, more active adults. Evidence suggests limited benefit in patients with OA who subsequently progress to knee replacement surgery. See comments under gender.		Prevalence increases with age.			Prevalence increases with age
Social deprivation	No issue	No issue	No issue	No issue	No issue		No issue
Carers	No issue	No issue	No issue	No issue	No issue		No issue
Human rights	No issue	No issue	No issue	No issue	No issue		No issue
SUMMARY: differential impact?	No differential impact for any aspect in terms of policy delivery as the decision to treat a patient will be made on clinical presentation rather than on the patient's alignment with any of the protected characteristics.						

Clinical Area → / Equality Strand ↓	Therapeutic Ultrasound in Physiotherapy	Shoulder Surgery	Ganglion Surgery	Spinal Facet Joint Injections	Spinal Epidural Injections	Spinal Fusion Surgery	Radiofrequency Denervation
Gender	Non site specific intervention used on a variety of soft tissue and sports injuries. It is not possible to define how these may impact on the different equality strands.	More common in men.	The prevalence in women is three times that in men. Mucous cysts more common in females than in males.	Unclear whether there is a gender related variance. There may be issues for women associated with osteoporosis, menstruation and pregnancy.			Patient.co.uk notes that there may be a higher prevalence of low back pain in women due to changes in posture associated with body changes (adolescence and pregnancy)
Race		Uncertain	No issue	No reported variance			
Disability		No issue	No issue	No issue	No issue	No issue	No issue
Religion/ belief		No issue	No issue	No issue	No issue	No issue	No issue
Sexual orientation		No issue	No issue	No issue	No issue	No issue	No issue
Age		Most commonly associated with age but also throwing sports which would suggest a younger cohort.	Most ganglions occur in persons aged 10-40 years, with a range from childhood to the ninth decade of life. Mucous cysts (ganglions of the distal interphalangeal joint) occur primarily in persons aged 40-70 years.	Incidence of low back pain is highest in the third decade, and overall prevalence increases with age until the 60-65 year age group and then gradually declines.			
Social deprivation		No issue	No issue	Low back pain is associated with low educational status and smoking both common in areas of social deprivation.			
Carers		Occurrence may be related to work involving lifting.	No issue	Lifting may contribute to low back pain			
Human rights		No issue	No issue	No issue	No issue	No issue	No Issue
SUMMARY: differential impact?	No differential impact for any aspect in terms of policy delivery as the decision to treat a patient will be made on clinical presentation rather than on the patient's alignment with any of the protected characteristics.						

Clinical Area → / Equality Strand ↓	Disc Replacement Surgery	Spinal Decompression	Acupuncture and Electrotherapies				
Gender	Patient.co.uk notes that there may be a higher prevalence of low back pain in women due to changes in posture associated with body changes (adolescence and pregnancy)	Patient.co.uk notes that there may be a higher prevalence of low back pain in women due to changes in posture associated with body changes (adolescence and pregnancy)	Rheumatoid arthritis affects women more than men. 70-80% of people affected by the autoimmune disease are female. Females are also more likely to develop Osteoarthritis (OA) Men have a 45% lower risk of knee OA and a 36% lower risk of hip OA than women.				
Race	No reported variance		The risks of developing RA vary with ethnic origin; the highest risks are recorded for Native American populations, in which prevalence is up to 4 times higher than it is in Europeans.				
Disability	No issue	No issue	Those with a physical disability may be so as it is connected to arthritis or back pain.				
Religion/ belief	No issue	No issue	No issue				
Sexual orientation	No issue	No issue	No issue				
Age	Incidence of low back pain is highest in the third decade; overall prevalence increases with age until 60-65 year age group and then gradually declines.		Older people are more affected and likely to develop musculoskeletal pain.				
Social deprivation	Low back pain is associated with low educational status and smoking both common in areas of social deprivation.		Obesity is a risk factor to developing arthritis. RH is genetic so not socio-economic factor.				
Carers	Lifting may contribute to low back pain		Caring may make a person more likely to develop OA and chronic back pain if responsibilities involve lifting/pushing manual handling etc.				
Human rights	No Issue	No Issue					
SUMMARY: differential impact?	No differential impact for any aspect in terms of policy delivery as the decision to treat a patient will be made on clinical presentation rather than on the patient's alignment with any of the protected characteristics.						

Equality Impact Assessment Action Plan

Strand	Issue	Action required	How will you measure the outcome/impact	Timescale	Lead