General Commissioning Policy

Treatment	Total Hip and Knee Replacement
For the treatment of	Osteoarthritis of the Hip and Knee
Background	This policy is needed in order to clarify the patient criteria which must be fulfilled in order for elective Hip and Knee Replacement procedures to be commissioned.
Commissioning position	Referral to an acute provider for consideration of hip and knee replacement surgery should only be made if specific criteria are met, as detailed at ***Appendix 3*** *Referral criteria elective Hip and Knee Replacements* for routine referral to orthopaedic services. Further information relating to *Hip and Knee replacement GP Guidance, Hip replacement Trust triage and Knee replacement Trust triage are detailed at* ***Appendix 4.*** **Hip Replacement** The most common indication for elective primary total hip replacement (THR) is degenerative arthritis (osteoarthritis) of the joint. Other indications include rheumatoid arthritis, injury, bone tumour and necrosis of the hip bone. The relevant 3-character OPCS codes6 (where used for elective primary hip replacement for osteoarthritis) include: W37 – Total prosthetic replacement of hip joint using cement W38 – Total prosthetic replacement of hip joint not using cement W39 – Other total prosthetic replacement of hip joint W93, W94, W95 - Hybrid prosthetic replacement of hip joint **Knee Replacement** The most common indication for elective total knee replacement (TKR) is degenerative arthritis (osteoarthritis) of the joint. Other indications include rheumatoid arthritis, osteonecrosis and other types of inflammatory arthritis. The relevant 3-character OPCS codes7 (where used for elective primary knee replacement for osteoarthritis) include: W40 Total prosthetic replacement of knee joint using cement W41 Total prosthetic replacement of knee joint not using cement W42 Other total prosthetic replacement of knee joint **Definitions of pain and functional limitation levels – *Appendix 1*** Smoking cessation and weight management should be considered as an integral part of appropriate clinical management prior to consideration of any elective surgery. Referral to smoking cessation and the appropriate weight management service should be completed as part of the primary care treatment for Hip and Knee conditions.

	Patients whose pain is so severe and/or mobility so compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this threat, or patients in whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulty of the procedure The CCG recognises there will be exceptional, individual or clinical circumstances when funding for treatments designated as low priority will be appropriate. Individual funding requests should only occur in exceptional circumstances where the patient does not meet the core criteria. In this instance the completion of an Individual Funding Request is required. All referrals to the provider should demonstrate how the patient has met the minimum referral criteria ***Appendix 3*** and the appropriate Hip or Knee proforma completed ***Appendix 2*****.** Incomplete referrals may be returned for further information. **Not routinely commissioned** – This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. **Restricted** – This means the CCG will fund the treatment if the patient meets the stated clinical threshold for care. (Hip and Knee Policy)
	August 2016
Summary of evidence / rationale	**Hip Replacement** A review of systematic reviews and health technology assessments looking at the evidence base for clinical measurement tools to assess referral threshold for hip replacement was undertaken in 2010 by the Aggressive Research Intelligence Facility (ARIF) at the University of Birmingham. This found no systematic reviews or health technology assessments that had directly investigated clinical measurement tools to help treatment decisions regarding hip replacement. However, it identified two clinical guideline documents that gave recommendations on referral of patients for hip replacement and one systematic review that examined the effectiveness of clinical pathways in the treatment of patients with hip pathology. Of the guidelines, one was issued by the National Institute for Health and Clinical Excellence (NICE). The NICE guidelines suggested that "referral for joint replacement surgery should be considered for people with osteoarthritis who experience joint symptoms (pain, stiffness, reduced function) that have a substantial impact on their quality of life and are refractory to non-surgical treatment. Referral should be made before there is prolonged and established functional limitation and severe pain."

A number of CCG's in England have existing published policies on thresholds for referral of patients with hip pain due to osteoarthritis from primary care to secondary care and/or thresholds for elective primary hip replacement surgery.

A local simple literature review was carried out to explore the range of commissioning policies for total hip replacement that were in place in CCG's nationally. Further to a review of 10 commissioning policy documents found covering 27 CCG's* the following has been identified and consistent in terms of policy and approach to the commissioning of primary total hip replacement surgery.

Background

There is a national trend toward increasing demand for joint replacement surgery, with the total number of operations growing from approximately 105,000 procedures in 2005 to approximately 178,073 replacement procedures in 2012 (source: National Joint Registry)

- 90,482 knee
- 84,488 hip
- 590 ankle
- 288 elbow
- 2,225 shoulder

Total hip replacement is a common intervention carried out in the NHS. The most frequent indication for this is degenerative osteoarthritis in adults (92% in 2012 diagnosed).

Complications occur in approximately one in 100 cases for hip replacement and can be severe (including pulmonary embolism) therefore should only be considered when other treatments have failed.

Knee Replacement

Guidelines on osteoarthritis issued by the National Institute for Health and Clinical Excellence (NICE) suggest that "referral for joint replacement surgery should be considered for people with osteoarthritis who experience joint symptoms (pain, stiffness, reduced function) that have a substantial impact on their quality of life and are refractory to non-surgical treatment. Referral should be made before there is prolonged and established functional limitation and severe pain."

A consensus statement from the British Orthopaedic Association and the British Association for Surgery of the Knee – published in 2001, but reported to be still current – states that "severe pain and disability with accompanying radiological changes in the knee are almost always the indications for the operation, in patients where conservative treatment has failed or is futile. Occasionally there may be an indication to replace a knee because of progressive deformity and/or instability, and pain may not necessarily be the most significant factor. Where comorbidities exist, risk benefit considerations may rule out the operation in an individual patient."

	A local simple literature review was carried out to explore the range of commissioning policies for total knee replacement that were in place in CCG's nationally. Further to a review of 11 commissioning policy documents found covering 18 CCG's* the aforementioned criteria within this policy was identified and consistent in terms of policy and approach to the NHS Hull CCG commissioning of primary total knee replacement surgery. **Background** Total knee replacement can be performed for a number of conditions, but it is most often for osteoarthritis of the knee (98% in 2012 diagnosed). Osteoarthritis of the knee presents with joint pain, deformity, stiffness, a reduced range of movement and sometimes giving way. Complications occur in approximately one in 20 cases for knee replacement and can be severe (including pulmonary embolism, ligament, artery or nerve damage and knee cap becoming dislocated) therefore should only be considered when other treatments have failed. Non-surgical management includes medications for pain and inflammation, weight reduction in patients who are overweight and obese via weight management programmes, walking aids, cushion-soled footwear. GP's can inject corticosteroids into the knee joint to relieve inflammation for periods of up to 6 -12 months. If these therapies are insufficient, a partial or total knee replacement may be necessary. The usual indications for a knee replacement are pain and disability with accompanying radiological changes. Occasionally knee replacements are done to manage a progressive deformity/instability. **Referral** Prior to referral for total hip and knee replacement, non-surgical treatments should be offered for all patients and the management of any underlying medical conditions should be optimised. This includes medications for pain and inflammation, education and advice, and weight reduction in patients via weight management programmes. Referral decisions should not be made on the basis of hip radiography as this is thought to be unreliable.
Date	August 2016
Review Date	June 2019
Contact for this policy	Karen Billany, Head of Acute Care NHS Hull Clinical Commissioning Group. karen.billany@nhs.net

References:

1. **NICE Pathways:** Management of Osteoarthritis: Referral for consideration of Joint Surgery
http://pathways.nice.org.uk/pathways/osteoarthritis#path=view%3A/pathways/osteoarthritis/management-of-osteoarthritis.xml&content=view-node%3Anodes-referral-for-consideration-of-joint-surgery

2. **NICE Clinical Guideline** Osteoarthritis 177
https://www.nice.org.uk/guidance/cg177

3. **Aggressive Research Intelligence Facility (ARIF) (2010) Clinical measurement tools and referrals for hip replacement.** http://www.arif.bham.ac.uk/reports/Report-Clinical-Measurement-Tools-and-Referrals-for-Hip-Replacement-April-2010.pdf

4. **The National Collaborating Centre for Chronic Conditions** (Royal College of Physicians) / National Institute for Health and Clinical Excellence (NICE) (2008) Osteoarthritis - National clinical guideline for care and management in adults.
http://www.nice.org.uk/nicemedia/pdf/CG059FullGuideline.pdf

5. **NHS Evidence** - National Library of Guidelines. Knee replacement: a guide to good practice.
http://www.library.nhs.uk/GuidelinesFinder/ViewResource.aspx?resID

Appendix 1

Definitions of pain and functional limitation levels

Pain Level

Mild	Pain interferes minimally on an intermittent basis with usual daily activities Not related to rest or sleep Pain controlled by one or more of the following; NSAIDs with no or tolerable side effects, aspirin at regular doses, paracetamol
Moderate	Pain occurs daily with movement and interferes with usual daily activities. Vigorous activities cannot be performed Not related to rest or sleep Pain controlled by one or more of the following; NSAIDs with no or tolerable side effects, aspirin at regular doses, paracetamol
Severe	Pain is constant and interferes with most activities of daily living Pain at rest or interferes with sleep Pain not controlled, even by narcotic analgesics

Functional Limitations

Minor	Functional capacity adequate to conduct normal activities and self-care Walking capacity of more than one hour No aids needed
Moderate	Functional capacity adequate to perform only a few or none of the normal activities and self-care Walking capacity of about one half hour Aids such as a cane are needed
Severe	Largely or wholly incapacitated Walking capacity of less than half hour or unable to walk or bedridden Aids such as a cane, a walker or a wheelchair are required

Variable	**Definition**
Mobility and Stability	
Preserved mobility and stable joint	Preserved mobility is equivalent to minimum range of movement from 0 to 90. Stable or not lax is equivalent to an absence of slackness of more than 5mm in the extended joint.
Limited mobility and /or stable joint	Limited mobility is equivalent to a range of movement less than 0 to 90. Unstable or lax is equivalent to the presence of slackness of more than 5mm in the extended joint.
Radiology	
Slight	Ahlback grade 1.
Moderate	Ahlback grade II and III.
Severe	Ahlback grade IV and V.

Appendix 2

Primary Hip Replacement Surgery

Referral Proforma for GPs

Patient Details		
Name:		
NHS Number:		
Date of Birth:		
Address:		
Clinician Details		
Name of Referring Clinician:		**Date:**
Practice ID:		
Practice Telephone Number:		

Please enter referral letter text here (optional).

Please state clearly if the referral is outside of policy and a specialist opinion is required, giving relevant clinical information i.e. the patients BMI is >35.

Appendix 2

Primary Knee Replacement Surgery

Referral Proforma for GPs

Patient Details		
Name:		
NHS Number:		
Date of Birth:		
Address:		
Clinician Details		
Name of Referring Clinician:		**Date:**
Practice ID:		
Practice Telephone Number:		

Please enter referral letter text here (optional).

Please state clearly if the referral is outside of policy and a specialist opinion is required, giving relevant clinical information i.e. the patients BMI is >35.

Appendix 3

Referral criteria elective Hip and Knee Replacements

Patients should meet all the following criteria and referred appropriately:

Referral should be made when other pre-existing medical conditions have been optimised **AND** conservative measures have been exhausted and failed.

Please refer to the referral criteria for Symptomology in the table overleaf.

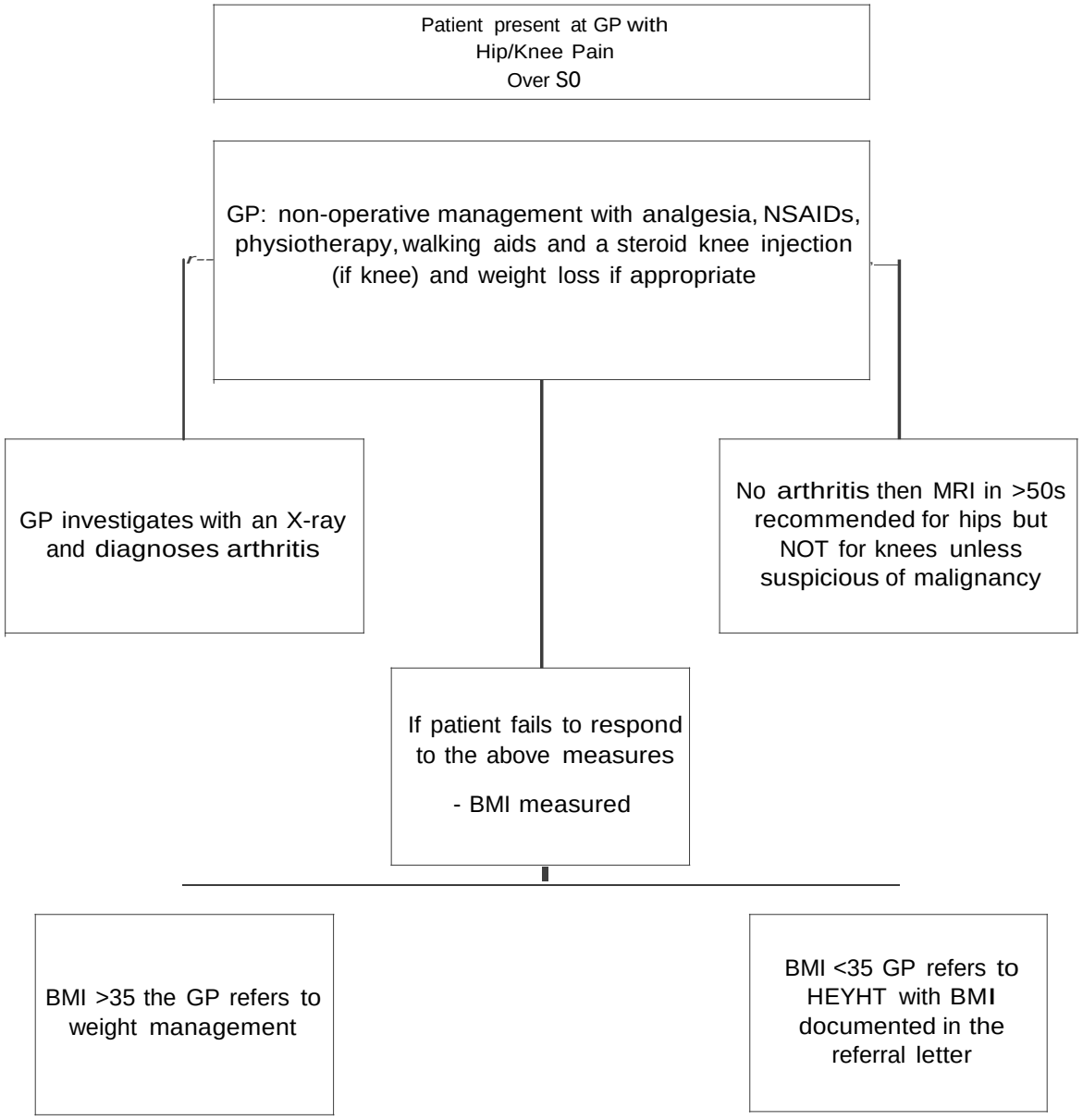
NHS Number: _____

Referral Criteria	*Tick boxes as appropriate*
The initial non-surgical management of hip and knee pain due to osteoarthritis **has been provided**, i.e. a package of care that may include weight management and weight reduction, activity modification, patient specific exercise programme, adequate doses of non-steroidal anti-inflammatory drugs (NSAIDs) and analgesics, joint injections, introducing walking aids, and other forms of physical therapies.	☐
Patient has a Body Mass Index of <35. (If the patients BMI is >35 patients should be referred for weight management interventions and upon 6 months of documented weight loss if the patient fails to lose weight to a BMI <35 then consider referral through IFR process.	☐
Patient has moderate to severe persistent pain not adequately relieved by an extended course of non-surgical management (including weight management)	☐
If patient is a smoker, date referred to smoking cessation services **Date:** _____	
AND Clinically significant functional limitation (moderate to severe) functional limitation resulting in diminished quality of life.	☐
AND Radiographic evidence of joint damage.	☐

Appendix4

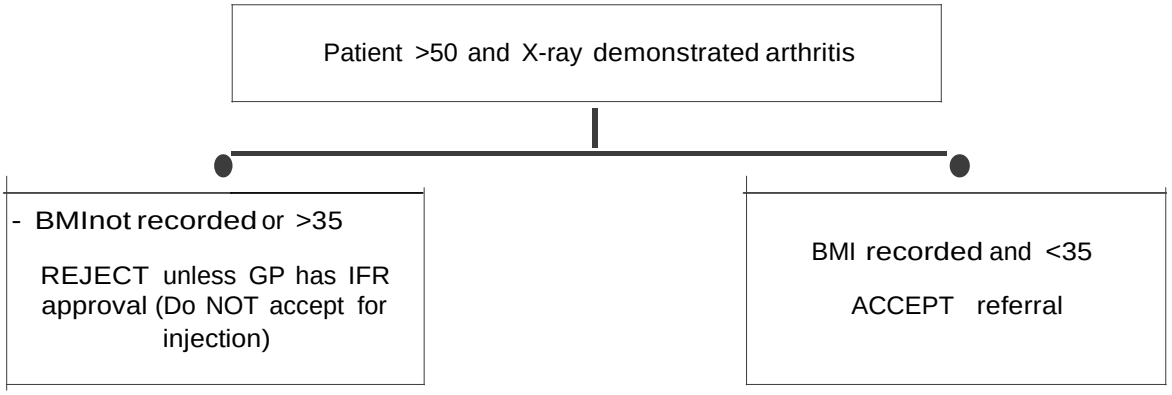
Hip and Knee replacement GP Guidance

GP Referral



Knee replacement Trust Triage

Over 50 Years

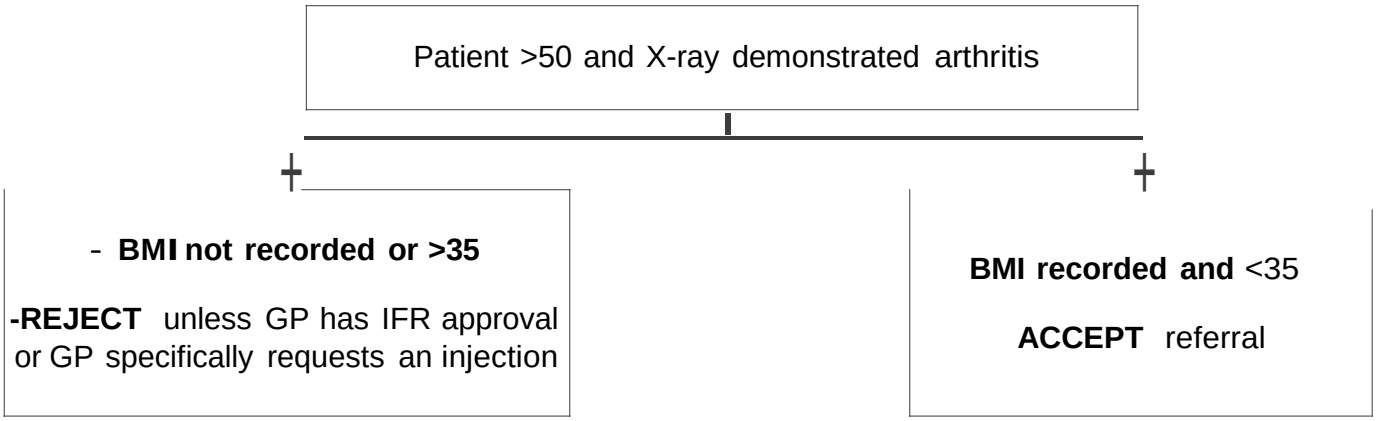


Under 50 years

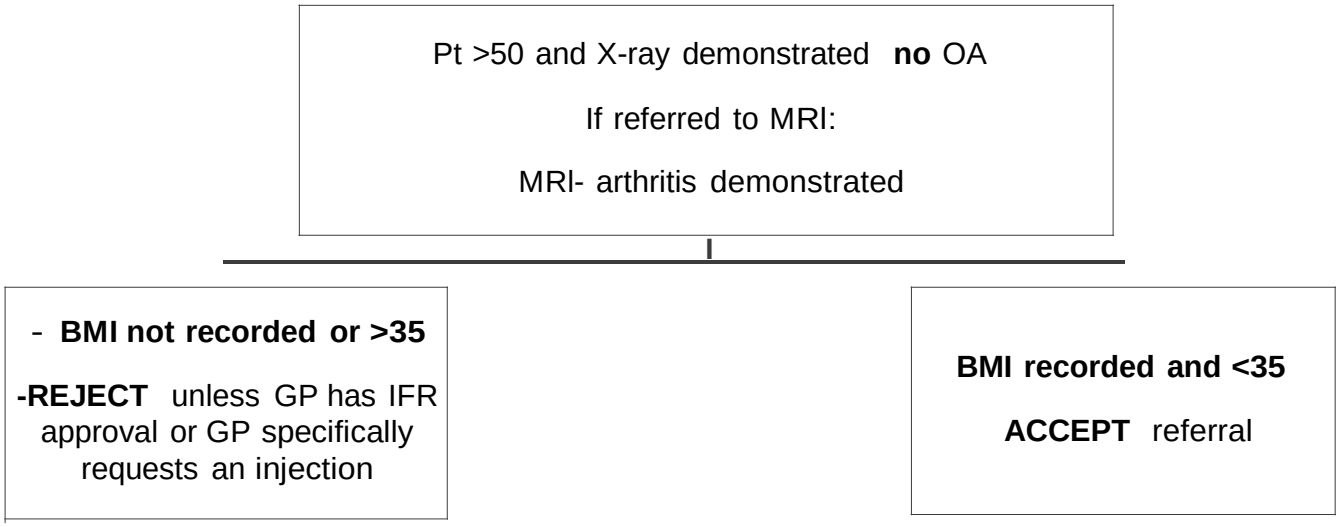
Patient <50 manage as current with x-ray then MRI if no x-ray abnormality then refer if significant pathology

Hip replacement Trust Triage

Over 50 Years



Over 50 NO Arthritis



Under 50 years with hip pain