NHS
Vale of York
Clinical Commissioning Group

24. Hip and Knee Replacement Commissioning Statement

Treatment	Hip and knee replacement for hip & knee arthritis - referral to secondary care
Background	This commissioning policy is needed in order to clarify the criteria for referral to secondary care for hip and knee replacement. The CCG is facing severe financial constraints and has decided to tighten thresholds for elective joint replacement surgery, particularly in relation to BMI. The Prevention and Better Health strategy[1] has been developed to demonstrate how focusing our efforts on prevention, self-care and shared decision making can support a shift in the way health care resources are valued, and to empower patients in the Vale of York to become more active participants in shaping their health outcomes
Commissioning position	NHS Vale of York CCG does NOT routinely commission referral to secondary care for hip or knee replacement for patients whose BMI is 35 or above. Exceptions to this threshold: • Revision hip surgery which is clinically urgent AND where delay could lead to significant deterioration/acute hospital admission. Includes infection, recurrent dislocations, impending peri-prosthetic fracture, gross implant loosening or implant migration. • Revision knee surgery which is clinically urgent AND where delay could lead to significant deterioration/acute hospital admission. Includes infection, impending peri-prosthetic fracture, gross implant loosening/migration, severe ligamentous instability. • Primary hip or knee surgery which is clinically urgent because there is rapidly progressive or severe bone loss that would render reconstruction more complex. • Orthopaedic procedures for chronic infection Please note: As part of the Prevention and Better Health strategy[1], patients with a BMI range of 30 to 35 will be covered by the Optimising Outcomes from All Elective Surgery Commissioning Statement[2] Also note that any patient who is a current smoker will also be covered by this statement, regardless of their BMI. Funding will ONLY be considered where criteria are met (see section 3). The clinician needs to ensure that the patient fulfils all the criteria and provides evidence of any of the clinical indications before they are referred to secondary care.

All other cases need to be referred for consideration by the Individual Funding request panel (IFR). For further information see IFR policies and guidance (including the referral form)

In line with NICE CG177 Care and Management in Osteoarthritis[3], patients should be offered advice on the following core treatments. (All conservative options should have been tried for at least 3 months.)

1. Non pharmacological management

- Agree individualised self-management strategies. Ensure that positive behavioural changes, such as paced activity / exercise, weight loss, use of suitable footwear and, are appropriately targeted
- Activity and exercise should be encouraged, irrespective of age, comorbidity, pain severity or disability. Exercise should include local muscle strengthening **and** general aerobic fitness.
- All patients must have taken part in regular tier 2 exercise, with support as available from any appropriate service eg local authority exercise trainers, NHS services where available or private gyms and personal coaches
- All patients must have undertaken a programme of physiotherapy, including manipulation and stretching as an adjunct to core treatments.
- Interventions to achieve weight loss must be offered if the person is overweight or obese (see NICE CG 43[4]).
- People with osteoarthritis who have biomechanical joint pain or instability should be considered for assessment for bracing/joint supports/insoles. Assistive devices (e.g. walking sticks) should be considered for people who have specific problems with activities of daily living. Referral to occupational therapy or podiatry may be appropriate
- TENS should be considered as option for pain relief
- DO NOT offer glucosamine or chondroitin products, or acupuncture, for the management of osteoarthritis

2. Pharmacological management

Arthritic pain is chronic nociceptive pain and drug management is covered in the RSS pathway guidance for pain relief.

This includes:

- Oral analgesia (eg regular paracetamol, cocodamol)
- Topical NSAIDs
- Oral NSAIDs eg ibuprofen 400mg tds or naproxen 500mg bd, with PPI cover.

At least three different types should be tried. Diclofenac and Cox2 inhibitors are not recommended because of the increased cardiovascular risk

- Intra-articular corticosteroid injections can be considered as an adjunct to core treatments, if appropriate, for the relief of moderate to severe pain in people with osteoarthritis[3]

3. Before any referral for surgery, patients also have to meet the following criteria:

- Experiencing moderate-to-severe persistent pain not adequately relieved by an extended course of non-surgical management. Pain is at a level at which it interferes with activities of daily living e.g. washing, dressing, lifestyle and sleep

AND

- Troubled by clinically significant functional limitation resulting in diminished quality of life AND
- Patients with a BMI range that is >30 but <35 meet the criteria covered by the Optimising Outcomes from All Elective Surgery commissioning statement[2] AND
- The patient has been a non-smoker for at least 8 weeks

AND

- Evidence that regular paced tier 2 activity/exercise has been undertaken, with physiotherapy support if appropriate

AND

- A simple x-ray to confirm diagnosis has been carried out

AND

- Evidence that PROMS data have been explained and discussed (see link http://www.valeofyorkccg.nhs.uk/rss/index.php?id=proms
- Evidence that the patient has had their options discussed via a shared decision-making tool

Patient Information

Further information for patients can be found the following website http://www.valeofyorkccg.nhs.uk/rss/index.php?id=prevention

4. Referring Clinician

Therefore the referring clinician must:

- Ensure patients are signposted to the most appropriate support required for their lifestyle changes
- Ensure that patients are advised to seek review by their GP or other appropriate health care professional should their condition change during the period for lifestyle changes
- Ensure patients who continue to smoke and are not able to reduce their BMI must be allowed to access clinically appropriate elective care after specified periods of time.
- Ensure patients who receive interventions contrary to this policy statement may still be able to access support post procedure to improve their lifestyles to minimise any disadvantage to their health.
- Vulnerable patients / patients with mental illness, learning

	disabilities or cognitive impairment will need to be clinically assessed to ensure that where they may be able to benefit from opportunities to improve lifestyle that are offered. (Please note that deferring elective interventions may be appropriate for some vulnerable patients based on clinical assessment of their ability to benefit from an opportunity to stop smoking/reduce their BMI/improve pre-operative fitness.) **5. The MSK service must refer all requests via the RSS and demonstrate that** • Patients with clinically urgent need do not experience avoidable delay • The recommended hierarchy of management within NICE CG177 Care and Management in Osteoarthritis[4] has been followed: non-pharmacological treatments first, then drugs, for at least 3 months • Adherence to the Optimising Outcomes from All Elective Surgery commissioning statement[2] for those patients within a BMI range that is >30 but <35 • Confirmation that patients have been made aware of the options available as an alternative to surgery and the risks associated with surgery, and have considered the PROMs data and used shared decision-making tools during the patient care pathway • Patients' fitness for surgery has been properly assessed and this is evidenced AND • Ensure that patients with significant co-morbidities [systemic or local] have appropriate investigations and treatment to optimise their condition before referral
Summary of evidence / rationale	Around 450 patients per 100,000 population will present to primary care with hip pain each year. Of these, 25% will improve within three months and 35% at twelve months; this improvement is sustained[5]. 20% of adults over 50 and 40% over 80 years report disability from knee pain secondary to osteoarthritis[6]. The majority of patients present to primary care with symptoms of pain and stiffness, which reduces mobility and with associated reduction in quality of life. Osteoarthritis may not be progressive and most patients will not need surgery, with their symptoms adequately controlled by non-surgical measures, as outlined by NICE[3]. Symptoms progress in 15% of patients with hip pain within 3 years and 28% within 6 years[5]. When patient's symptoms are not controlled by up to 3 months of non-operative treatment they become candidates for assessment for joint surgery. The decision to have joint surgery is based on the

	patient's pre-operative levels of symptoms, their capacity to benefit, their expectation of the outcome and attitude to the risks involved. Patients should make shared decisions with clinicians, using decision support such as the NHS Decision Aid for knee osteoarthritis[6]. Obesity is an increasing problem in the population and also a significant risk factor for osteoarthritis. It is often associated with comorbidities such as diabetes, IHD, HT and sleep apnoea. Some years ago, an Arthritis Research Campaign Report[7] stated that joint surgery is less successful in obese patients because 1. **Obese patients have a significantly higher risk of a range of short-term complications during and immediately after surgery** (eg longer operations, excess blood loss requiring transfusions, DVT, wound complications including infection). 2. The heavier the patient, the **less likely** it is that surgery will bring about **an improvement in symptoms** (eg they are less likely to regain normal functioning or reduction in pain and stiffness) 3. The implant is **likely to fail more quickly**, requiring further surgery (eg within 7 years, obese patients are more than 10 times as likely to have an implant failure); 4. People who have joint replacement surgery because of obesity-related osteoarthritis are **more likely to gain weight post-operatively** (despite the new opportunity to lose weight through exercise following reduction in pain levels) It also concluded that "**Weight loss and exercise combined have been shown to achieve the same level of symptom relief as joint replacement surgery**". A study of obese patients with knee osteoarthritis found that those who **dropped their weight by 10%** after a combination of diet and exercise reported less pain, better knee function, improved mobility and enhanced quality of life[8]. A recent extensive literature review advises assessment of "**timely weight loss as a part of conservative care**"[9]. It confirms in detail the increased risk of many perioperative and postoperative complications associated with obesity (as well as increased costs and length of stay), such as wound healing/infections; respiratory problems; thromboembolic disease; dislocation; need for revision surgery; component malposition; and prosthesis loosening.
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Author	Dr Alison Forrester, Healthcare Public Health Advisor VOYCCG Andrew Bucklee, Head of Commissioning & Delivery, VoYCCG
Approved by	

NHS
Vale of York
Clinical Commissioning Group

Responsible Officer	Dr Shaun O'Connell, GP Lead Valeofyork.contactus@nhs.net

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