## General Commissioning Policy

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Total Hip and Knee Replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>For the treatment of</td>
<td>Osteoarthritis of the Hip and Knee</td>
</tr>
<tr>
<td>Background</td>
<td>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.</td>
</tr>
<tr>
<td>Commissioning position</td>
<td>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.</td>
</tr>
</tbody>
</table>

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 codes (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 codes (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.

<table>
<thead>
<tr>
<th>Date</th>
<th>August 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review Date</td>
<td>June 2019</td>
</tr>
</tbody>
</table>
| 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

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


### Definitions of pain and functional limitation levels

#### Pain Level

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>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.</td>
</tr>
<tr>
<td>Moderate</td>
<td>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.</td>
</tr>
<tr>
<td>Severe</td>
<td>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.</td>
</tr>
</tbody>
</table>

#### Functional Limitations

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td>Functional capacity adequate to conduct normal activities and self-care. Walking capacity of more than one hour. No aids needed.</td>
</tr>
<tr>
<td>Moderate</td>
<td>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.</td>
</tr>
<tr>
<td>Severe</td>
<td>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.</td>
</tr>
</tbody>
</table>

#### Variable Definition

<table>
<thead>
<tr>
<th>Mobility and Stability</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preserved mobility and stable joint</td>
<td>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.</td>
</tr>
<tr>
<td>Limited mobility and/or stable joint</td>
<td>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.</td>
</tr>
</tbody>
</table>

#### Radiology

<table>
<thead>
<tr>
<th>Level</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slight</td>
<td>Ahlback grade 1.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Ahlback grade II and III.</td>
</tr>
<tr>
<td>Severe</td>
<td>Ahlback grade IV and V.</td>
</tr>
</tbody>
</table>
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**

<table>
<thead>
<tr>
<th>Patient Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>NHS Number:</td>
</tr>
<tr>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinician Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Referring Clinician:</td>
</tr>
<tr>
<td>Practice ID:</td>
</tr>
<tr>
<td>Practice Telephone Number:</td>
</tr>
</tbody>
</table>

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: _______________________

<table>
<thead>
<tr>
<th>Referral Criteria</th>
<th>Tick boxes as appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>☐</td>
</tr>
<tr>
<td>Patient has a Body Mass Index of &lt;35. (If the patients BMI is &gt;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 &lt;35 then consider referral through IFR process.)</td>
<td>☐</td>
</tr>
<tr>
<td>Patient has moderate to severe persistent pain not adequately relieved by an extended course of non-surgical management (including weight management)</td>
<td>☐</td>
</tr>
<tr>
<td>If patient is a smoker, date referred to smoking cessation services</td>
<td></td>
</tr>
<tr>
<td>Date: ____________________________</td>
<td></td>
</tr>
<tr>
<td>AND Clinically significant functional limitation (moderate to severe) functional limitation resulting in diminished quality of life.</td>
<td>☐</td>
</tr>
<tr>
<td>AND Radiographic evidence of joint damage.</td>
<td>☐</td>
</tr>
</tbody>
</table>
Appendix 4

Hip and Knee replacement GP Guidance

**Patient present at GP with Hip/Knee Pain Over 50**

**GP: non-operative management with analgesia, NSAIDs, physiotherapy, walking aids and a steroid knee injection (if knee) and weight loss if appropriate**

**GP investigates with an X-ray and diagnoses arthritis**

**No arthritis then MRI in >50s recommended for hips but NOT for knees unless suspicious of malignancy**

**If patient fails to respond to the above measures**
- BMI measured

**BMI >35 the GP refers to weight management**

**BMI <35 GP refers to HEYHT with BMI documented in the referral letter**
Knee replacement Trust Triage

Over 50 Years

Patient >50 and X-ray demonstrated arthritis

- BMI not recorded or >35
  REJECT unless GP has IFR approval (Do NOT accept for injection)

  BMI recorded and <35
  ACCEPT referral

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

Patient >50 and X-ray demonstrated arthritis

- BMI not recorded or >35
  - REJECT unless GP has IFR approval or GP specifically requests an injection

BMI recorded and <35
  ACCEPT referral

Over 50 NO Arthritis

Pt >50 and X-ray demonstrated no OA
  If referred to MRI:
    MRI- arthritis demonstrated

- BMI not recorded or >35
  - REJECT unless GP has IFR approval or GP specifically requests an injection

BMI recorded and <35
  ACCEPT referral

Under 50 years with hip pain

Pt <50 with hip pain
  X-ray and MRI
  no X-ray arthritis
  Referred to secondary care with BMI may be rejected if THR only option

NHS Hull CCG Total Hip and Replacement Policy August 2016