Berkshire West Clinical Commissioning Group

Procedure funded subject to Audit

Thames Valley Priorities Committee Commissioning Policy Statement

Policy No. TVPC 49	**Patients with osteoarthritis (OA); primary hip and knee replacement**
Recommendation made by the Priorities Committee:	September 2016; updated November 2018[1] and January 2019[2]
Date of issue:	**April 2019**

In addition to the Thames Valley Priorities Committee statement below, the following requirements also need to be met for all patients of Berkshire West CCG:
1. A fully populated MSK proforma must be sent by the GP and received by the orthopaedic service in all providers prior to the patient being offered a first appointment, or the referral will be rejected.
2. The evidence sent with the MSK proforma must clearly show that the patient has either completed the shared decision making process or by providing the Arthritis Care certificate proving that the patient has been seen by Arthritis Care prior to referral (where referring condition is *primary hip or knee replacement for osteoarthritis).
3. For orthopaedic surgeon opinion only requests, the letter must state clearly "for opinion only" and all providers to give opinion only and patient to be referred back to GP for Primary Care management.
4. All providers are to ensure the populated MSK proforma is documented within the patient's paper notes.
* Patients with a previous hip/knee replacement on one side may be an exception.

From 10 February 2020, all Berkshire West patients with a knee related condition need to be seen by the Berkshire West Triage service prior to referral to secondary care and therefore any referrals directly from GPs for Berkshire West patients should be rejected by secondary care.

The majority of patients with osteoarthritis (OA) of the hip or knee can initially be managed adequately in primary and intermediate care by following the NICE Clinical Guideline 177 (2014) and Quality Standard 87 (2015) for care and management of OA. Summary guidance notes overleaf.

Adults aged 45 or over can be diagnosed with OA clinically, without investigations if they have activity-related joint pain and any morning joint stiffness lasts no longer than 30 minutes. Primary or intermediate care x-ray is not necessary as part of routine investigations.

Referral for specialist assessment can be considered for patients who meet **all** the following criteria 1 – 6:

1. Patient experiences joint symptoms (pain, stiffness and reduced function) that have a substantial impact on their quality of life defined as interfering with their activities of daily living or their ability to sleep.

2. Patient has been offered at least the core (non-surgical) treatment options recommended by NICE CG177;

[1] UKR included.
[2] Reference to patient decision aid has been removed; no other changes have been made.

- Access to information (accurate verbal and written information to enhance understanding of the condition and its management, and to counter misconceptions, such as that it inevitably progresses and cannot be treated).
- Activity and exercise irrespective of age, comorbidity, pain severity or disability. Exercise should include: local muscle strengthening and general aerobic fitness.
- Patients who are overweight BMI > 25kg/m2 are offered support and interventions to lose weight and this has been documented.
- Patients with BMI ≥ 35kg/m2 must have completed a recognised weight management programme.

3. Joint symptoms are refractory to non-surgical treatments listed overleaf including where appropriate and not contra-indicated; analgesia, steroid injections, local heat and cold therapy.

4. Patients have a right to be fully informed about this procedure. As part of this process, clinicians should engage the patients (or their carers) in shared decision making about alternative management and the risks and benefits of surgery.

5. Patient has confirmed they wish to have surgery.

6. Any underlying medical conditions have been investigated and the patient's condition has been optimised.

Further advice and support as appropriate should be offered including:

- Agree individualised self-management strategies with the person with osteoarthritis.

- Manipulation and stretching should be considered as an adjunct to core treatments, particularly for osteoarthritis of the hip.

- Advice on appropriate footwear (including shock-absorbing properties) as part of core treatments for people with lower limb osteoarthritis.

- Assistive devices (for example walking sticks) should be considered as adjuncts to core treatments for people with osteoarthritis who have specific problems with activities of daily living.

- Local heat and cold therapy.

- Analgesia: paracetamol, non-steroidal anti-inflammatory medication (topical or oral with proton pump inhibitor [PPI]), oral opioid.

- Intra-articular corticosteroid injections should be offered as an adjunct to core treatments for the relief of moderate to severe pain in people with both knee and hip osteoarthritis, according to local provision.

- Patients who smoke should be advised to attempt to stop smoking at least 4 weeks before surgery to reduce the risk of surgical and post-surgery complications.

Unicompartmental Knee Replacement (UKR)

UKR is an option for clinically appropriate patients who meet the criteria above. UKR is a complex procedure and therefore it is recommended that contractual minimum annual volumes for UKR are agreed with providers, in collaboration with the orthopaedic specialist societies, as discussed in the GIRFT (2015) National Review of Adult Elective Orthopaedic Services in England report.

NOTES:

- Potentially exceptional circumstances may be considered by a patient's CCG where there is evidence of significant health status impairment (e.g. inability to perform activities of daily living) and there is evidence that the intervention sought would improve the individual's health status.
- This policy will be reviewed in the light of new evidence or new national guidance, eg, from NICE.
- Thames Valley clinical policies can be viewed at http://www.fundingrequests.cscsu.nhs.uk/

Audit codes

Total Hip Replacement

Primary OPCS:
W37.1: Primary total prosthetic replacement of hip joint using cement
W37.9: Unspecified total prosthetic replacement of hip joint using cement
W38.1: Primary total prosthetic replacement of hip joint not using cement
W38.9: Unspecified total prosthetic replacement of hip joint not using cement
W39.1: Primary total prosthetic replacement of hip joint NEC
W39.9: Unspecified other total prosthetic replacement of hip joint
W93.1: Primary hybrid prosthetic replacement of hip joint using cemented acetabular component
W93.9: Unspecified hybrid prosthetic replacement of hip joint using cemented acetabular component
W94.1: Primary hybrid prosthetic replacement of hip joint using cemented femoral component
W94.9: Unspecified hybrid prosthetic replacement of hip joint using cemented femoral component
W95.1: Primary hybrid prosthetic replacement of hip joint using cement NEC
W95.9: Unspecified hybrid prosthetic replacement of hip joint using cement

Secondary OPCS:
Bilateral:
Z94.1: Bilateral operation or
Z94.2: Right sided operation and Z94.3: Left sided operation
Unilateral:
Z94.2: Right sided operation or
Z94.3: Left sided operation or
Z94.4: Unilateral operation

Total Knee Replacement

Primary OPCS:
W40.1: Primary total prosthetic replacement of knee joint using cement
W40.9: Unspecified total prosthetic replacement of knee joint using cement
W41.1: Primary total prosthetic replacement of knee joint not using cement
W41.9: Unspecified total prosthetic replacement of knee joint not using cement
W42.1: Primary total prosthetic replacement of knee joint NEC
W42.9: Unspecified other total prosthetic replacement of knee joint
O18.1: Primary hybrid prosthetic replacement of knee joint using cement
O18.9: Unspecified hybrid prosthetic replacement of knee joint using cement

Unicompartmental Knee Replacement

W58.1: Primary resurfacing arthroplasty of joint