NHS
Ipswich and East Suffolk
Clinical Commissioning Group

T18a Policy
Referral and Treatment Criteria for Hip Replacement

Policy author: Ipswich and East & West Suffolk CCG
Policy start date: June 2007 (formally T9)
Revision date: January 2011
2nd Revision date: March 2014
Review date: March 2016

Ipswich and East & West Suffolk CCGs will **only** fund hip replacement for osteoarthritis when conservative measures have failed (listed below) or its successor AND the following criteria have been met. Patient's clinical condition must be clearly documented during a clinical encounter prior to surgical decision and documentation must include dates and description of measures.

(If more than one joint replacement is being considered EACH surgery requires evaluation against the criteria set forth on its own merits. Of particular note if a patient has completed a joint replacement and another joint replacement is being considered, a complete re-evaluation of their condition for functional limitations and pain will be required as part of the request)

- Referral to the Hip Pathway (This will include completion of Stage 2 – preparation for surgery) **AND**
- Patient has a BMI of less than 35 (Patients with BMI>=35 should be referred to for weight management interventions and upon 6 months of documented weight loss attempt with dates and intervention types- if the patient fails to lose weight to a BMI less than 35 then may consider referral through the IFR process.) **AND**
- Intense to severe persistent pain (defined in table one and documentation to support is required) which leads to severe functional limitations (defined in table two and documentation to support is required), ***OR***
- Minor or moderate functional limitation (defined in table two and documentation to support is required) affecting the patients quality of life despite 6 months of conservative measures including referral to the local hip pathway or its successor.

Exceptions include:

a. Patients whose pain is so severe and/or mobility is compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this.
b. Patients in whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure.

****Conservative measures:***

1. Patient education such as elimination of damaging influence on hips, activity modification (avoid impact and excessive exercise), good shock-absorbing shoes and lifestyle adjustment. Documentation of this is required. **AND**

2. Physiotherapy – Minimum of a 12 week programme including physiotherapy or Referral to Stage 1 of the CCG Hip Pathway **AND**
3. Oral NSAIDS a minimum of 3 weeks and paracetamol based analgesics (COX-2 Inhibitor of NSAIDS). Opiod analgesics can be used effectively if paracetamol or NSAIDS are ineffective or poorly tolerated. Documentation of dates and medication types is required.

Rationale behind the policy decision / Further Rationale for Conservative Measures documented in the Policy:

Guidance from NICE, musculoskeletal services framework from the Department of Health; GP training Network and the National Institute of Health Consensus panel suggests1-4:
- Common MSK pain including lower limb pain ideally should be managed in primary care.
- Primary care practitioners need direct access to therapy, dietetics and health promotion services.
- Primary care management should seek to maximize the benefits of surgery and minimize complications when surgery is necessary.

There is also evidence in the published reports to support a correlation between obesity and complications following hip replacement surgery. Obesity has been found to be a specific risk factor for joint infection after total hip replacement.

A meta-analysis of 16 controlled trials found individual exercise and self-management had a moderate but clinically significant psychological effect and positive contribution to the patient's emotional well-being.

Studies have shown manual therapy, individualised or group therapy to reduce pain and improve function significantly.

References:

1. NICE. Primary care referral guidelines for common conditions 2003; London
2. National Institute of health. Concensus development program. Dec 2003
3. The musculoskeletal services framework – A joint responsibility: doing it differently. Department of Health. 2006.
4. Namba, R., Paxton, L., Fithian, D., and Stone, M. Obesity and perioperative morbidity in total hip and total knee arthroplasty patients. J Arthroplasty 20(7) Supplement 3 (2005), 46-50.
5. Hawkeswood MD, J.,Reebye MD, R. Evidence-based guidelines for the nonpharmacological treatment of osteoarthritis of the hip and knee. Issue: BCMJ, Vol. 52, No. 8, October 2010, page(s) 399-403 Articles.
6. National Health and Medical Research Council. The Royal Australian
7. College of General Practitioners. 'Guideline for the non-surgical management of hip and knee osteoarthritis. July 2009.InterQualR. Total Joint Replacement Hip Procedures criteria. 2013.
8. NICE. TA44 Metal on Metal Hip Resurfacing. Updated 04 January 2013.
9. NHS England. Interim Clinical Commissioning Policy: Hip Resurfacing. November 2013.

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T18b Policy
Referral and Treatment criteria for Knee Replacement

Policy author: Ipswich and East & West Suffolk CCG
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The Ipswich and East & West Suffolk CCGs will **only** fund knee replacement for osteoarthritis when conservative measures have failed (listed below) or its successor and the following criteria have been met:

Referral Criteria:

1. Referral to Knee Pathway - This will include completion of Stage 2 – preparation for surgery **AND**
2. Osteoarthritis of the knee causes persistent, severe pain* **AND**
3. Pain from osteoarthritis of the knee leads to significant loss of functional ability and reduction in quality of life** **AND**
4. Symptoms have not adequately responded to 6 months of conservative measures (see below) OR conservative measures are contraindicated **AND**
5. Patient has a BMI of less than 35 (Patients with BMI>35 should be referred to for weight management interventions and upon 6 months of documented weight loss attempt with dates and intervention types- if the patient fails to lose weight to a BMI less than 35 then may consider referral through the IFR process.)

*These can be evaluated using table 1, see references.
**These can be evaluated using table 2, see references.

Exceptions include:
a. Patients whose pain is so severe and/or mobility is compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this.
b. Patients in whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure.

Conservative measures:

1. Patient education such as elimination of damaging influence on knees, activity modification (avoid impact and excessive exercise), good shock-absorbing shoes and lifestyle adjustment. Documentation of this is required. **AND**
2. Physiotherapy - Minimum of a 12 week programme including physiotherapy or Referral to Stage 1 of the CCG Hip Pathway **AND**
3. Oral NSAIDS a minimum of 3 weeks and paracetamol based analgesics (COX-2 Inhibitor of NSAIDS). Opiod analgesics can be used effectively if paracetamol or NSAIDS are ineffective or poorly tolerated. Documentation of dates and medication types is required.
4. Intra-articular steroid injections when facility is available in primary care.

Management should be patient centred, therefore treatment should be appropriate to the age, occupation, lifestyle and comorbidities of the individual. Some or all of the above interventions may not be appropriate in all patients, and all treatment options should be discussed and agreed with the patients themselves.

Rationale behind the policy decision

Guidance from NICE[1], musculoskeletal services framework from the Department of Health[2] and the National Institute of Health Consensus panel[3] suggests:

- Common MSK pain including knee pain ideally should be managed in primary care.
- Primary care practitioners need direct access to orthosis, therapy, dietetics and health promotion services.
- Primary care management should seek to maximize the benefits of surgery and minimize complications when surgery is necessary.

NICE recommend knee replacement is reserved for patients with symptoms that have a substantial impact on their quality of life AND are refractory to conservative measures[1] . The CCG have therefore devised a simple classification system to allow clinicians in primary care to identify patients with severe, persistent pain and significant functional loss so that they can be referred for surgery, in keeping with the recommendations of NICE.

For more information please see the Evidence brief that informed the development of this policy.

References

1. http://www.nice.org.uk/nicemedia/pdf/CG59quickrefguide.pdf
2. http://www.susanoliver.com/pdf/MSF_Final.pdf
3. NIH Consens State Sci Statements. 2003 Dec 8-10;20(1):1-34.

Table 1: Classification of pain level [1]

Pain Level	
Slight	Sporadic pain.(May be daily but comes and goes 25% or less of one's day) Pain when climbing/descending stairs. Allows daily activities to be carried out (those requiring great physical activity may be limited). (Able to bathe, dress, cook, and maintain house) Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects.
Moderate	Occasional pain.)May be daily and occurs 50-75% of one's day) Pain when walking on level surfaces (half an hour, or standing). Some limitation of daily activities.(Occasionally has difficulty with self care and home maintenance) Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects.
Intense	Pain of almost continuous nature.(Occurs 75-100% of one's day) Pain when walking short distances on level surfaces (>20ft) or standing for less than half an hour. Daily activities significantly limited. (unable to maintain home, cook,bathe or dress without difficulty or assistance) Continuous use of NSAIDs for treatment to take effect. Requires the sporadic use of support systems walking stick, crutches).
Severe	Continuous pain. (Occurs 100% of the time) Pain when resting. Daily activities significantly limited constantly. (Requires assistance to maintain home, bathe, and dress) Continuous use of analgesics - narcotics/NSAIDs with adverse effects or no response. Requires more constant use of support systems (walking stick, crutches).

Table two: Functional Limitations[2]

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 of the normal activities and self care Walking capacity of between half and one hour Aids such as a cane are needed occasionally
Severe	Largely or wholly incapacitated Walking capacity of less than half hour Cannot move around without aids such as a cane, a walker or a wheelchair AND help of a carer is required.

[1] Lequesne M. Indices of severity and disease activity for osteoarthritis. Seminars in Arthritis Research, 1991;20:48-54

[2] Hochberg et al. The American College of Rheumatology 1991 revised criteria for the classification of global functional status in rheumatoid arthritis. Arthritis Rheum, 1992;35:498-502