Item Number: 7.2

Name of Presenter: Shaun O'Connell

Meeting of the Governing Body

1 September 2016

NHS
Vale of York
Clinical Commissioning Group

Commissioning Statement for Hip and Knee Joint Replacement Surgery

Purpose of Report
For Approval

Rationale

NHS Vale of York CCG is in the process of reviewing its commissioning statements for procedures that are not routinely commissioned.

The review of commissioning statements is usually carried out by the Clinical Research and Effectiveness Committee, and adapted by the Quality and Finance Committee of the CCG. This specific statement is being brought to the Governing Body for endorsement, as it relates to the proposed strategy detailed in item 7.1

Strategic Priority Links

☐Primary Care/ Integrated Care
☐Urgent Care
☐Effective Organisation
☐Mental Health/Vulnerable People
☒Planned Care/ Cancer
☐Prescribing
☒Financial Sustainability

Local Authority Area

☒CCG Footprint
☐City of York Council
☐East Riding of Yorkshire Council
☐North Yorkshire County Council

Impacts/ Key Risks

☒Financial
☐Legal
☒Primary Care
☒Equalities

Recommendations

1. Support the implementation of the Commissioning Statement for Hip and Knee Joint Replacement Surgery

Responsible Chief Officer and Title Dr Shaun O'Connell, GP Lead for Planned Care and Prescribing	**Report Author and Title** Dr Shaun O'Connell, GP Lead for Planned Care and Prescribing Polly Mason Improvement and Innovation Manager Dr Alison Forrester Healthcare public health advisor

Hip and Knee Joint Replacement Joint Surgery Commissioning Statement
Commissioning Statement: 24

Treatment	**Hip and knee joint replacement surgery**
For the treatment of	**Hip and knee arthritis**
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 significant financial challenge and wishes to implement its Prevention and Better Health Strategy. In doing so it has decided to tighten thresholds for elective joint replacement surgery, particularly in relation to BMI and smoking. Recent analysis of the RightCare Commissioning for Value Focus Pack for Vale of York CCG shows that the CCG has a higher rate of elective total hip and knee replacement surgery than demographically similar CCGs. The reasons for this are being explored.
Commissioning position	NHS Vale of York CCG does not routinely commission referral to secondary care for hip or knee replacement. In line with NICE CG177 Care and Management in Osteoarthritis[1], 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. Such encouragement should be mindful of the limitations of co-morbidity and 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 engaged with 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[2]). • 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 • Glucosamine or chondroitin products should not be recommended on the NHS nor should acupuncture, for the management of osteoarthritis 2. **Pharmacological management** Arthritic pain is chronic nociceptive pain and drug management is covered in this RSS link This includes: • Oral analgesia (eg regular paracetamol, co-codamol) • 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 Cox 2 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[1] **3. Before 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 • The patient is fit for surgery with a BMI ≤30. Patients with a BMI >30 should be advised and given appropriate support to address lifestyle factors that would improve their fitness for surgery. A baseline weight should be established at referral or first assessment. Referral for surgery should be delayed until the patient has lost at least 10% of their body weight or for 12 months (with the aim of them losing at least 10% of their weight before surgery) AND

- The patient is a non-smoker prior to surgery Referral for surgery should be delayed until the patient has stopped smoking for 8 weeks, or for 6 months 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 within the past 6 months AND

- Evidence that PROMS data have been explained and discussed (see links http://www.valeofyorkccg.nhs.uk/rss/index.php?id=proms

  (Also new draft version http://maraiddesign.com/ESRC-Project/index.html)

- Evidence that the RightCare shared decision-making tools have been used[3] (see links http://sdm.rightcare.nhs.uk/pda/osteoarthritis-of-the-hip/print-summmary http://sdm.rightcare.nhs.uk/pda/osteoarthritis-of-the-knee/print-summmary http://sdm.rightcare.nhs.uk/shared-decision-making-sheets/

Further information for patients available… (see patient information leaflet)

4. **The MSK service must refer all requests via the RSS and demonstrate that**

- The recommended hierarchy of management within NICE CG177 Care and Management in Osteoarthritis has been followed: non-pharmacological treatments first, then drugs, for at least 3 months
- Weight loss of at least 10%, or an attempt has been made over-12 months by patients with a BMI >30
- Patient has stopped smoking for 8 weeks, or an attempt has been made over 6 months
- Confirmation that patients have been made aware of the options available as an alternative to surgery and the risks associated with surgery, and have signed a proforma to say they've considered the PROMs data and used the RightCare shared decision-making tools[4]
- Patients' fitness for surgery has been properly assessed

	and this is evidenced AND • Oxford hip or knee pain scoring has taken place and the score indicates severe symptoms eg. 24 or less (scoring tools have to be used in conjunction with other clinical information[3]) • Ensure that patients with significant co-morbidities [systemic or local] have appropriate investigations and treatment to optimise their condition before referral Patients who meet the criteria will be assessed by the Referral Support Service for booking into secondary care Patients who do not meet the criteria will require prior approval through the NHS Vale of York CCG Individual Funding Request Panel (IFR). For patients who do not fulfil the above criteria, funding will only be considered where there are exceptional clinical circumstances. Their clinician needs to submit an application to VoY CCG Individual Funding Request Panel (IFR).
Effective from	TBC
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[4]. 20% of adults over 50 and 40% over 80 years report disability from knee pain secondary to osteoarthritis[5]. 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[1]. Symptoms progress in 15% of patients with hip pain within 3 years and 28% within 6 years[4]. 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[5] 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[6] 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[7]. A recent extensive literature review advises assessment of "**timely weight loss as a part of conservative care**"[8]. 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.
Date	July 2016
Review Date	July 2018
Contact for this policy	Dr Shaun O'Connell GP Lead for Planned Care and Prescribing.

References:

1. Care and Management of Osteoarthritis NICE Clinical Guidelines CG177 Feb 2014 http://www.nice.org.uk/guidance/CG177/chapter/1-Recommendations#referral-for-consideration-of-joint-surgery-

2. Obesity prevention NICE CG 43 Dec 2006; last amended March 2015 https://www.nice.org.uk/guidance/cg43

3. RightCare shared decision-making tools

   http://sdm.rightcare.nhs.uk/shared-decision-making-sheets/

   http://sdm.rightcare.nhs.uk/pda/osteoarthritis-of-the-hip/print-summmary

http://sdm.rightcare.nhs.uk/pda/osteoarthritis-of-the-knee/print-summmary

4. Royal College of Surgeons Commissioning Guides: Painful osteoarthritis of the hip November 2013 http://www.rcseng.ac.uk/healthcare-bodies/docs/commissioning-guides-boa/painful-hip-commissioning-guide

5. Royal College of Surgeons Commissioning Guides:Painful osteoarthritis of the knee November 2013 http://www.rcseng.ac.uk/healthcare-bodies/docs/commissioning-guides-boa/osteoarthritis-of-the-knee-final/view

6. Arthritis Research Campaign: "Osteoarthritis and Obesity" (2009) http://www.arthritisresearchuk.org/external-resources/2012/09/17/15/29/osteoarthritis-and-obesity-a-report-by-the-arthritis-research-campaign.aspx

7. Effects of intensive diet and exercise on knee joint loads, inflammation, and clinical outcomes among overweight and obese adults with knee osteoarthritis: the IDEA randomised controlled trial Messier et al JAMA 310(12) 1263-73 (2013) http://www.ncbi.nlm.nih.gov/pubmed/2406501

8. Obesity and total joint arthroplasty: a literature based review. Journal of Arthroplasty May 2013 http://www.arthroplastyjournal.org/article/S0883-5403(13)00174-5/abstract

APPENDIX 1: EQUALITY IMPACT ANALYSIS FORM

1.	**Title of policy/ programme/ service being analysed**
	Commissioning statement for hip and knee joint replacement surgery
2.	**Please state the aims and objectives of this work.**
	To ensure that all patients approaching hip and knee joint replacement surgery are encouraged to adopt a healthier lifestyle by reducing their BMI to below 30 and stopping smoking. This will optimise their long-term health and reduce risks of complications from surgery.
3.	**Who is likely to be affected? (e.g. staff, patients, service users)**
	Patients/Service Users
4.	**What sources of equality information have you used to inform your piece of work?**
	Data from providers Local demographic data
5.	**What steps have been taken ensure that the organisation has paid due regard to the need to eliminate discrimination, advance equal opportunities and foster good relations between people with protected characteristics**
	The need to pay due regard to equalities issues is included as part of the CCG's Constitution and the development of equalities impact assessments is a fundamental part of the policy development process.
6.	**Who have you involved in the development of this piece of work?**
	GP Clinical Leads Data analysts

7.	**What evidence do you have of any potential adverse or positive impact on gro ups with protected characteristics?** **Do you have any gaps in information?** **Include any supporting evidence e.g. research, data or feedback from engagement activities** **(Refer to** Error! Reference source not found. if your piece of work relates to commissioning activity to gather the evidence during all stages of the commissioning cycle)

Disability People who are learning disabled, physically disabled, people with mental illness, sensory loss and long term chronic conditions such as diabetes, HIV)	Consider building access, communication requirements, making reasonable adjustments for individuals etc
This may have an adverse effect on people with disabilities. Data for hospital discharges for 2015 shows that 8% of people discharged from York Teaching Hospital Foundation Trust were identified as having a disability, but this has not been broken down further by elective/ non-elective surgery. See mitigating actions below.	
Sex Men and Women	Consider gender preference in key worker, single sex accommodation etc

The data on elective surgery from York Hospital Teaching Foundation Trust for April 2015-March 2016 show that 43% of males and 57% of females of working age had an elective procedure, while the proportions for the 65+ age group were equal.

Age Banding	Female	Male	TOTAL
19-64 years	11823	8895	20718
65+ years	10275	10660	20935

The population health data for the Yorkshire & Humber region area show that 24.5% of adult males and 27.4% of females were classified as obese for 2008-10, and therefore females are more likely to be affected. Source: http://www.healthyork.org/lifestyles-in-york/weight-and-obesity.aspx

Race or nationality People of different ethnic backgrounds, including Roma Gypsies and Travellers	Consider cultural traditions, food requirements, communication styles, language needs etc.

There is insufficient evidence to show that any particular ethnicity would be disproportionately affected. Where data is available, the numbers of people receiving elective surgery is proportionate to the demographic composition of the population as a whole.

Age This applies to all age groups. This can include safeguarding, consent and child welfare	Consider access to services or employment based on need/merit not age, effective communication strategies etc.

This policy may have a greater impact in terms of numbers on people of older age groups who are proportionately more likely to need elective surgery. The overall numbers of people receiving elective procedures at York THFT in the 65+ age groups are equivalent to the numbers of working age population, although the 65+ population represents a smaller percentage of the overall demographic.	
Trans People who have undergone gender reassignment (sex change) and those who identify as trans	Consider privacy of data, harassment, access to unisex toilets & bathing areas etc.
There is insufficient evidence to show that people of transgender status would be adversely affected.	
Sexual orientation This will include lesbian, gay and bi-sexual people as well as heterosexual people.	Consider whether the service acknowledges same sex partners as next of kin, harassment, inclusive language etc.
There is insufficient evidence to show that people of transgender status would be adversely affected.	
Religion or belief Includes religions, beliefs or no religion or belief	Consider holiday scheduling, appointment timing, dietary considerations, prayer space etc.

There is insufficient evidence to show that people of any particular religion or faith group would be adversely affected.	
Marriage and Civil Partnership Refers to legally recognised partnerships (employment policies only)	Consider whether civil partners are included in benefit and leave policies etc.
The policy has been evaluated against marital status, and no evidence of impact has been found.	
Pregnancy and maternity Refers to the pregnancy period and the first year after birth	Consider impact on working arrangements, part-time working, infant caring responsibilities etc.
There is insufficient evidence to show that pregnancy or maternity would have an impact.	
Carers This relates to general caring responsibilities for someone of any age.	Consider impact on part-time working, shift-patterns, options for flexi working etc.
There is insufficient evidence to show that carers would be affected disproportionately.	

Other disadvantaged groups This relates to groups experiencing health inequalities such as people living in deprived areas, new migrants, people who are homeless, ex-offenders, people with HIV.	Consider ease of access, location of service, historic take-up of service etc

8.	**Action planning for improvement** Please outline what mitigating actions have been considered to eliminate any adverse impact? The Council of Representatives will be consulted to identify the clinical appropriateness of applying the policy to specific groups of patients and so identify exceptions to the policy. Under the Individual Funding Request (IFR) process, individuals who believe they fall outside the standard requirements and policies of the CCG are entitled to make an exceptional request for funding, which should be discussed with their GP. Please state if there are any opportunities to advance equality of opportunity and/ foster good relationships between different groups of people?

Sign off
Name and signature of person / team who carried out this analysis
Date analysis completed
Name and signature of responsible Director
Date analysis was approved by responsible Director