Commissioning Policy
Individual Funding Request

Hip Replacement Surgery – including referral for Surgical Assessment of Osteoarthritis
Criteria Based Access Policy
Date Adopted: 1st June 2016
Version: 1617.1.01

Individual Funding Request Team - A partnership between Bristol, North Somerset and South Gloucestershire Clinical Commissioning Groups
<table>
<thead>
<tr>
<th>Internal Version</th>
<th>Date</th>
<th>Reviewer</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td>1617.1</td>
<td>03/05/2016</td>
<td>IFR Manager</td>
<td>Policy reviewed and agreed by Board.</td>
</tr>
<tr>
<td>1617.1.01</td>
<td>20/10/2017</td>
<td>IFR Coordinator</td>
<td>To remove reference to MSK as “intermediate care”.</td>
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</table>
This is a Criteria Based Access Policy
Treatment may be provided where patients meet the criteria below
This policy relates to all patients

Hip Replacement Surgery (including referral for Surgical Assessment of Osteoarthritis Policy)

Policy Statement & Date of Adoption: 1st June 2106

Hip replacement surgery including referral for surgical assessment of osteoarthritis policy is not routinely funded by the CCG and is subject to this restricted policy.

General Principles
Treatment should only be given in line with these general principles. Where patients are unable to meet these principles, in addition to the specific treatment criteria set out in this policy, funding approval may be sought from the Clinical Commissioning Group’s (CCG) Individual Funding Request Panel by submission of an IFR application.

1. All patients must be referred for an initial assessment and, where appropriate, conservative management, to commissioned musculoskeletal services. Musculoskeletal services will assess a patient’s suitability for surgery including: reference to this policy, manage patients conservatively when possible and where appropriate refer patients to secondary care for further management of their condition:
   - Bristol Patients – Musculoskeletal Assessment and Treatment Service (MATS) and Spinal Service
   - North Somerset Patients – The Musculoskeletal Interface Service
   - South Gloucestershire Patients - Clinical/Spinal Assessment & Treatment Service

2. For patients who do not qualify for a referral to, or do not wish to be assessed by, musculoskeletal services, individual funding approval must be secured by primary care prior to referring patients seeking advice and/or corrective surgery in secondary care. Referring patients to secondary care without funding approval having been secured not only incurs significant costs in out-patient appointments for patients that may not qualify for surgery, but inappropriately raises the patient’s expectation of treatment.

3. On limited occasions, the CCG may approve funding for a further assessment in secondary care only in order to confirm or obtain evidence demonstrating whether a patient meets the criteria for funding. In such cases, patients should be made aware that the assessment does not mean that they will be provided with surgery and surgery will only be provided where it can be demonstrated that the patients meets the criteria to access treatment in this policy.

4. Where funding approval is given by the Individual Funding Request Panel, it will be available for a specified period of time, normally one year.
5. Funding approval will only be given where there is evidence that the treatment requested is effective and that the patient has the potential to benefit from the proposed treatment. Where it is demonstrated that a patient has previously been provided with the treatment with limited or diminishing benefit, funding approval is unlikely to be agreed.

6. Patients with an elevated BMI of 30 or more are likely to receive fewer benefits from surgery and should be encouraged to lose weight further prior to seeking surgery. In addition, the risks of surgery are significantly increased (Thelwall, 2015).

7. Patients who are smokers should be referred to smoking cessation services in order to reduce the risk of surgery and improve healing (Loof, 2014).

8. Patients’ (and carers’ as appropriate) expectations of surgery, and the likely degree of additional benefit that may be obtained from surgery compared with continuing conservative management, must have been discussed in primary care/ Musculoskeletal. Patients must have been made aware of and given an opportunity in primary care to complete the Decision Aid tool on Hip replacements. These can be found here:
   http://sdm.rightcare.nhs.uk/pda/
   http://sdm.rightcare.nhs.uk/pda/osteoarthritis-of-the-hip/

Background
Reducing Inappropriate Referrals
This policy sets out when it is appropriate to manage patients conservatively in primary care and when to refer for further assessment and management.

Osteoarthritis of the Hips
The main symptoms of osteoarthritis are pain and stiffness in joints; which can make it difficult to move the affected joints and do certain activities. The symptoms may come and go in episodes, which can be related to things such as activity levels and even the weather. In more severe cases, the symptoms can be continuous.

Osteoarthritis in hips often causes difficulty moving hip joints. For example, a patient may find it difficult to put shoes and socks on or to get in and out of a car. Patients will also usually have pain in the groin or outside the hip. This will often be worse when they move their hip joints, although it can also affect them when resting or sleeping.

Diagnosing Osteoarthritis
Appropriate imaging such as X-Rays can be used to support diagnosis. NICE recommend that a diagnosis of osteoarthritis may possibly be made if the patient has the following symptoms:

- 45 years of age or older, and
- has joint pain that gets worse the more they use their joints, and
- has no stiffness in their joints in the morning, or stiffness that lasts no longer than 30 minutes.

(NICE, 2014)
There is no definitive test to diagnose osteoarthritis although an assessment of symptoms and examination of joints may help determine whether a patient has the condition. In addition, the assessment can include reference to the Oxford Hip Score and pain classification levels such as that referenced below.

**Conservative Measures Must Include All of The Following - As Recommended By NICE:**
NICE state, in TAG 304, that “artificial hips and hip resurfacing are recommended as possible treatments for people with end-stage arthritis of the hip”. In addition they recommend that prior to this a patient should be managed conservatively, including:

- Weight reduction where appropriate, particularly when the patient has a BMI greater than 35 (NICE, 2006), and
- Education and self-management such as elimination of damaging influence on hips, activity modification (avoid impact and excessive exercise), good shock-absorbing shoes, and
- Non-pharmacological management such as biomechanical interventions, physiotherapy and exercising to improve local muscle strength and general aerobic fitness (note: physiotherapy is ineffective in bone on bone osteoarthritis).
- Management with medication including where appropriate oral/topical nonsteroidal anti-inflammatory drugs [NSAIDS] and paracetamol based analgesics (COX-2 Inhibitor of NSAIDS). Opioid analgesics can be used effectively if paracetamol or NSAIDS are ineffective or poorly tolerated.

**Exceptions**
The requirement to undergo conservative management does not apply for immediate/urgent referral to orthopaedic services in respect of:

- Evidence of infection in the hip joint.
- Conditions (such as AVN-avascular necrosis) leading to a rapid deterioration in the joint where delay to treatment would be unreasonable.

**Commissioned Hip Prosthesis**
The National Institute for Clinical Excellence guidance states that setting a standard revision rate for prostheses lower than that of 5% at 10 years, is appropriate. Therefore, the prostheses to be used must have rates (or projected rates) of revision of 5% or less at 10 years, i.e. must be ODEP 10A rated, on a trajectory to achieve this rating, or within an ODEP-approved multicentre research trial. (NICE, 2014)

**Classification of Pain Level and Functional Impairment**
This guide below is produced to support all clinicians and patients in classifying the pain and/or impairment suffered due to their condition in order to judge whether it is the appropriate time to refer a patient to secondary care. (Lequense, MG. 1997)
Pain Levels:

Slight
- Sporadic pain.
- Pain when climbing/descending stairs.
- Allows daily activities to be carried out (those requiring great physical activity may be limited).
- Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects.

Moderate
- Occasional pain.
- Pain when walking on level surfaces (half an hour, or standing).
- Some limitation of daily activities.
- Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects.

Intense
- Pain of almost continuous nature.
- Pain when walking short distances on level surfaces or standing for less than half an hour.
- Daily activities significantly limited.
- Continuous use of NSAIDs for treatment to take effect.
- Requires the sporadic use of support systems walking stick, crutches).

Severe
- Continuous pain.
- Pain when resting.
- Daily activities significantly limited constantly.
- Continuous use of analgesics - narcotics/NSAIDs with adverse effects or no response.
- Requires more constant use of support systems (walking stick, crutches).

Functional Impairment

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 or none of the normal activities and self-care
- Walking capacity of about one half hour
- Aids such as a cane are needed

Severe
- 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
### Clinician’s Guide: When and Where to Refer?

<table>
<thead>
<tr>
<th>Pain</th>
<th>Functional Impairment</th>
<th>Minor</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
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<tbody>
<tr>
<td>Slight</td>
<td>Manage Conservatively in Primary Care – do not refer without funding approval</td>
<td>Manage Conservatively in Primary Care – do not refer without funding approval</td>
<td>Consider a referral to MSK for further conservative management and advice MSK to manage conservatively</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>Manage Conservatively in Primary Care – do not refer without funding approval</td>
<td>Manage Conservatively in Primary Care – do not refer without funding approval</td>
<td>Consider a referral to MSK for further conservative management and advice MSK to manage conservatively</td>
<td></td>
</tr>
<tr>
<td>Intense</td>
<td>Consider a referral to MSK for further conservative management and advice MSK to manage conservatively</td>
<td>MSK Review and where appropriate referral to Secondary Care</td>
<td>MSK Review and where appropriate referral to Secondary Care</td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>Consider a referral to MSK for further conservative management and advice MSK to manage conservatively</td>
<td>MSK Review and where appropriate referral to Secondary Care</td>
<td>Consider referral immediately if risk of losing mobility</td>
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### Risks of hip replacement surgery

The most common complication of hip replacement is that something goes wrong with the joint, which occurs in around 1 in 10 cases.

- **Joint problems:**
  - **Loosening of the joint** - Signs that the joint has become loose include pain and feeling that the joint is unstable. Another operation (revision surgery) may be necessary, although this cannot be performed in all patients.
  - **Hip dislocation** - In around 3% of cases the hip joint can come out of its socket. This is most likely to occur in the first few months after surgery when the hip is still healing.
Further surgery will be required to put the joint back into place.

- **Wear and tear** - Another common complication of hip replacement surgery is wear and tear of the artificial sockets. Particles that have worn off the artificial joint surfaces can be absorbed by surrounding tissue, causing loosening of the joint.

- **Joint stiffening** - The soft tissues can harden around the implant, causing reduced mobility.

- **Serious complications**

  Serious complications of a hip replacement are uncommon, occurring in fewer than one in a 100 cases:

  - **Blood clots** - There is a small risk of developing a blood clot in the first few weeks after surgery.
  
  - **Infection** - There is always a small risk that some bacteria could work its way into the tissue around the artificial hip joint, triggering an infection. *(NHS Choices, 2014)*

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**Policy - Criteria to Access Treatment – CRITERIA BASED ACCESS**

Referral to secondary care and subsequent treatment may be provided where patients meet the criteria below:

1) The patient has been assessed (including paper based triage where appropriate) by Musculoskeletal Services and diagnosed as suffering from end-stage osteoarthritis suitable for referral for consideration of surgery,

   **AND**

2) The patient has:

   a) Fully engaged with conservative measures for a period of at least six months (clearly detailed throughout the patient’s primary care record or via Musculoskeletal Services’ clinic letters), as detailed within this policy, and this has failed to improve the symptoms of the patient,

   **AND**

   b) The patient is suffering from intense or severe persistent pain with moderate or severe functional impairment when compared to the classification system on the previous page.

   **OR**

3) The patient has severe persistent pain and severe functional impairment which is compromising their mobility to such an extent that they are in immediate danger of losing their independence and joint replacement would relieve this.

   **OR**

4) The patient is at risk of destruction of their joint of such severity that delaying surgical correction would increase the technical difficulties of the procedure.
Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy.

Individual cases will be reviewed at the CCG’s Individual Funding Request Panel upon receipt of a completed application form from the patient’s GP, consultant or clinician. Applications cannot be considered from patients personally.

If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Patient Advice and Liaison Service on 0800 073 0907 or 0117 947 4477.

Connected Policies

**Hip Impingement**: Treatment will not be offered under this policy. Clinician’s should refer to the intervention specific policy.

This policy has been developed with the aid of the following references:


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In line with NICE guidance, the prostheses to be used must have rates (or projected rates) of revision of 5% or less at 10 years, i.e. must be ODEP 10A rated, on a trajectory to achieve this rating, or within an ODEP-approved multicentre research trial. (NICE, 2014)

**Exclusions:**

The provision of specialist custom hip prosthesis is not routinely commissioned and surgical clinicians will need to apply for Individual Funding approval in such circumstances setting out why it is proposed to use a custom device and why they patient is unable to be treated with standard devices.