TITLE	**CCG Policy for Patients with osteoarthritis (OA); primary hip and knee replacement**
FOR CONSIDERATION BY	Health Overview and Scrutiny Committee on 17 September 2018
WARD	
DIRECTOR	

OUTCOME / BENEFITS TO THE COMMUNITY
RECOMMENDATION The Health Overview and Scrutiny Committee are asked to note and discuss the CCG's Policy
SUMMARY OF REPORT

Background

Introduction

The CCG worked with the other CCGs in Thames Valley to develop and review Commissioning Policies. The Thames Valley Priorities Committee oversees this programme of work and makes recommendations to the CCG's Governing Body. The decision to adopt a policy rests with each individual CCG.

In developing their commissioning policies the CCGs operate within an Ethical Framework based on eight principles:

1. Equity
2. Health care need and capacity to benefit
3. Evidence of clinical effectiveness
4. Evidence of cost effectiveness
5. Cost of treatment and opportunity costs
6. Needs of the community
7. National Policy and Guidance
8. Exceptional need

These are described in Ethical Framework at Appendix 1

Primary Hip and Knee Replacement

The four CCGs in Berkshire West reviewed and updated their policy in June 2018. The primary purpose of the policy is to ensure that the patients who undergo surgery are those that are most likely to derive a clinical benefit from the procedure. To achieve this a number of evidence based criteria have been established to identify those patients most likely to benefit. GPs referring patients to hospital must ensure that the patient meets the criteria in order for the hospital to accept the patient.

There are also occasions where the GP would simply like advice and support on how to manage a patient's condition and they will refer to a hospital consultant for opinion.

We have also had significant success locally for patients with the opportunity to discuss the full range of options open to them away from the GP surgery. This service is commissioned by the CCG from Arthritis Care and patients have the opportunity to participate in a shared decision making process where they consider all options including surgery to manage their condition so they can choose the most appropriate option for them.

The results so far show that approximately 75% of patients choose conservative methods to manage their condition e.g. weight loss or exercise, rather than surgery. These results significantly exceeded the CCG's expectation and the patient feedback was so positive that we now want all patients to have this opportunity.

Our policy now requires that GPs must demonstrate that the patient has had the opportunity to consider alternatives prior to referral.

All surgery carries some risk and is best avoided if patients can alleviate their symptoms through weight loss and exercise, which also have wider benefits.

Patients who will clearly benefit from surgery will be referred in the usual way.

Patients can choose which hospital they wish to go to for their operation. Patients in Berkshire West are treated within the 18 week referral to treatment standard

Analysis of Issues

N/A

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Newbury and District Clinical Commissioning Group
North and West Reading Clinical Commissioning Group
South Reading Clinical Commissioning Group
Wokingham 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

Date of issue: **October 2017/**updated June 2018[1]

In addition to the Thames Valley Priorities Committee statement below, the following requirements also need to be met for patients of:
Newbury and District CCG, North and West Reading CCG, South Reading CCG and Wokingham 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.

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] Patient Decision Aid reference and link removed.

- 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/m^2 are offered support and interventions to lose weight and this has been documented.
- Patients with BMI ≥ 35kg/m^2 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. Patient has confirmed they wish to have surgery.

5. 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.

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, e.g., 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

NHS Aylesbury Vale Clinical Commissioning Group
NHS Bracknell and Ascot Clinical Commissioning Group
NHS Chiltern Clinical Commissioning Group
NHS Newbury and District Clinical Commissioning Group
NHS North and West Reading Clinical Commissioning Group
NHS Oxfordshire Clinical Commissioning Group
NHS South Reading Clinical Commissioning Group
NHS Slough Clinical Commissioning Group
NHS Windsor, Ascot and Maidenhead Clinical Commissioning Group
NHS Wokingham Clinical Commissioning Group

THAMES VALLEY PRIORITIES COMMITTEE

ETHICAL FRAMEWORK

Background

A primary responsibility of the commissioners of NHS health care in England is to make decisions about which treatments and services should be funded for their designated populations. This includes making decisions about the continued funding of currently-commissioned treatments and services, as well as the introduction of new treatments and approaches to the delivery of care.

Commissioners are subject to a statutory duty not to exceed their annual financial allocation. Further, the NHS needs to make savings to narrow the substantial financial gap in order to continue to meet the demands for care and treatment[1]. As the demand for NHS health care exceeds the financial resources available, commissioners are faced with difficult choices about which services to provide for their local populations.

The Priorities Committee has representatives of the NHS organisations across ten Thames Valley Clinical Commissioning Groups (CCGs) and includes lay members as well as clinicians and managers. The purpose of the Priorities Committee is to make recommendations, in the form of policies, to the local CCGs as to the services and health care interventions that should or should not be funded.

To help in this process, health care commissioners in the Thames Valley region have developed a decision-making tool - the 'Ethical Framework', to facilitate fairness and transparency in the priority-setting process.

The Ethical Framework was originally developed in 2004 by the NHS public health organisation *Priorities Support Unit* (now *Solutions for Public Health)*

[1] Five year forward view (2014) https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

and the Berkshire PCTs. Since then, the Framework has been revised to take account of policy developments in the NHS and changes in the law, and has been adopted more widely.

The purpose of the Ethical Framework

The purpose of the ethical framework is to support and underpin the decision making processes of constituent organisations and the Priorities Committee to support consistent commissioning policy through:

- Providing a ***coherent structure*** for the consideration of health care treatments and services to ensure that all important aspects are discussed.

- Promoting ***fairness and consistency*** in decision making from meeting to meeting and with regard to different clinical topics, reducing the potential for inequity.

- Ensuring that the ***principles and legal requirements of the NHS Constitution***[2] the ***Public Sector Equality Duty***[3] and the requirement to involve the public when making significant changes to the provision of NHS healthcare[4] are adhered to.

- Providing a transparent means of ***expressing the reasons*** behind the decisions made to patients, families, carers, clinicians and the public.

- Supporting and integrating with the development of CCG Commissioning Plans.

Formulating policy recommendations regarding health care priorities involves the exercise of judgment and discretion and there will be room for disagreement both within and outwith the Committee. Although there is no objective measure by which such decisions can be based, the Ethical Framework enables decisions to be made within a consistent setting which respects the needs of individuals and the community.

The following Ethical Framework consists of 8 principles or relevant considerations that will be taken into account in the development of each recommendation. It does not prejudge the weight that any one consideration is given nor does it require that all should be given equal weight.

[2] The NHS Constitution http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx
[3] Equality Act 2010: guidance (June 2015 update) https://www.gov.uk/guidance/equality-act-2010-guidance
[4] Transforming Participation in Health and Care NHS England (2013)

1. EQUITY

The Committee believes that people should have access to health care on the basis of need. There may also be times when some categories of care are given priority in order to address health inequalities in the community. However, the Committee will not discriminate, or limit access to NHS care, on grounds of personal characteristics including: age, race, religion, gender or gender identity, sex or sexual orientation, lifestyle, social position, family or financial status, pregnancy, intelligence, disability, physical or cognitive functioning. However, in some circumstances, these factors may be relevant to the clinical effectiveness of an intervention and the capacity of an individual to benefit from the treatment.

2. HEALTH CARE NEED AND CAPACITY TO BENEFIT

Health care should be allocated justly and fairly according to need and capacity to benefit. The Committee will consider the health needs of people and populations according to their capacity to benefit from health care interventions. As far as possible, it will respect the wishes of patients to choose between different clinically and cost effective treatment options, subject to the support of the clinical evidence.

This approach leads to three important principles:

- In the absence of evidence of health need, treatment will not generally be given solely because a patient requests it.
- A treatment of little benefit will not be provided simply because it is the only treatment available.
- Treatment which effectively treats “life time” or long term chronic conditions will be considered equally to urgent and life prolonging treatments.

3. EVIDENCE OF CLINICAL EFFECTIVENESS

The Committees will seek to obtain the best available evidence of clinical effectiveness using robust and reproducible methods. Methods to assess clinical and cost effectiveness are well established. The key success factors are the need to search effectively and systematically for relevant evidence, and then to extract, analyse, and present this in a consistent way to support the work of the Committee. Choice of appropriate clinically and patient-defined outcomes need to be given careful consideration, and where possible quality of life measures should be considered.

The Committees will promote treatments and services for which there is good evidence of clinical effectiveness in improving the health status of patients and will not normally recommend treatment and services that cannot be shown to be effective. For example, is the product likely to save lives or significantly improve quality of life? How many patients are likely to benefit? How robust is the clinical evidence that the treatment or service is effective?

When assessing evidence of clinical effectiveness the outcome measures that will be given greatest importance are those considered important to patients' health status. Patient satisfaction will not necessarily be taken as evidence of clinical effectiveness. Trials of longer duration and clinically relevant outcomes data may be considered more reliable than those of shorter duration with surrogate outcomes. Reliable evidence will often be available from good quality, rigorously appraised studies. Evidence may be available from other sources and this will also be considered. Patients' evidence of significant clinical benefit is relevant.

The Committee will also take particular account of patient safety. It will consider the reported adverse impacts of treatments and the licence status of medicines and the authorisation of medical devices and diagnostic technologies for NHS use.

4. EVIDENCE OF COST EFFECTIVENESS

The Committees will seek information about cost effectiveness in order to assess whether interventions represent value for money for the NHS. The Committees will compare the cost of a new treatment to the existing care provided and will also compare the cost of the treatment to its overall benefit, both to the individual and the community. The Committee will consider studies that synthesise costs and effectiveness in the form of economic evaluations (e.g. quality adjusted life years, cost-utility, cost-benefit), as they enable the relationship between costs and outcomes of alternative healthcare interventions to be compared, however, these will not by themselves be decisive.

Evidence of cost effectiveness assists understanding whether the NHS can afford to pay for the treatment or service and includes evidence of the costs a new treatment or service may release.

5. COST OF TREATMENT AND OPPORTUNITY COSTS

Because each CCG is duty-bound not to exceed its budget, the cost of a treatment must be considered. A single episode of treatment may be very expensive, or the cost of treating a whole community may be high. This is important because of the overall proportion of the total budget: funds invested in these areas will not be available for other health care interventions.
The Committees will compare the cost of a new treatment to the existing care provided, and consider the cost of the treatment against its overall health benefit, both to the individual and the community. As well as cost information, the Committees will consider the numbers of people in their designation populations who might be treated.

6. NEEDS OF THE COMMUNITY

Public health is an important concern of the Committee and they will seek to make decisions which promote the health of the entire community. Some of these decisions are promoted by the Department of Health (such as the guidance from NICE and Health and Social Care Outcomes Framework). Others are produced locally. The Committee also supports effective policies to promote preventive medicine which help stop people becoming ill in the first place.

Sometimes the needs of the community may conflict with the needs of individuals. Decisions are difficult when expensive treatment produces very little clinical benefit. For example, it may do little to improve the patient's condition, or to stop, or slow the progression of disease. Where it has been decided that a treatment has a low priority and cannot generally be supported, a patient's doctor may still seek to persuade the CCG that there are exceptional circumstances which mean that the patient should receive the treatment.

7. NATIONAL POLICY DIRECTIVES AND GUIDANCE

The Department of Health issues guidance and directions to NHS organisations which may give priority to some categories of patient, or require treatment to be made available within a given period. These may affect the way in which health service resources are allocated by individual CCGs. The Committee operates with these factors in mind and recognise that their discretion may be affected by Health and Social Care Outcomes Frameworks[5], NICE technology appraisal guidance, Secretary of State Directions to the NHS and performance and planning guidance.

Locally, choices about the funding of health care treatments will be informed by the needs of each individual CCG and these will be described in their Local Delivery Plan.

8. EXCEPTIONAL NEED

There will be no blanket bans on treatments since there may be cases in which a patient has special circumstances which present an exceptional need for treatment. Individual cases are considered by each respective CCG. Each case will be considered on its own merits in light of the clinical evidence. CCGs have procedures in place to consider such exceptional cases through their Individual Funding Request Process.

[5] https://www.gov.uk/government/collections/health-and-social-care-outcomes-frameworks