Knee Replacement Surgery (including Partial and Total Knee Replacement with or without Patella Replacement or Resurfacing)
Criteria Based Access

Before consideration of referral for management in secondary care, please review advice on the Remedy website (www.remedy.bnssg.icb.nhs.uk /) or consider use of advice and guidance services where available.

Section A - Criteria to Access Treatment

Funding approval for surgical treatment will only be provided by the ICB for patients meeting criteria set out 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 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

3) The patient:

   a) 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

   b) Has significant instability of the knee joint affecting the patient on a daily basis,

OR

   c) Has radiological features of severe disease with moderate functional impairments;

AND

4) The patient:

a) 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

b) Has significant instability of the knee joint affecting the patient on a daily basis,

OR

c) Has radiological features of severe disease with moderate functional impairments;

OR

d) Has radiological features of moderate disease or instability of the knee joint affecting the patient on a daily basis,

OR

4) The patient has severe persistent pain that is causing 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, and conservative management as set out in this policy is contra-indicated.

OR

5) 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.

Commissioned Prosthesis

The ICB will only fund standard prostheses conforming with NICE guidelines and that are Orthopaedic Data Evaluation Panel [ODEP] 10A rated, on a trajectory to achieve this rating, or within an ODEP-approved multicentre research trial. (Orthopaedic Data Evaluation Panel).

Kneecap resurfacing or replacement

Where patients have evidence of tri-compartmental OA affecting the kneecap, resurfacing or replacement of the patella can be proposed. However, the long-term results are still unclear with a recent meta-analysis showing the difference of absolute risk of reoperation between resurfacing and non-resurfacing being only 4% implying that in order to prevent one reoperation one would have to resurface 25 patellae. (Fu Y, 2011).

Kneecap resurfacing or replacement – Commissioned procedure (Monitor and NHS England, 2016)**.** Tri- compartmental knee surgery under the HRG code **"HB21C Major Knee Procedures for Non-Trauma, Category 2, without CC"** is the routinely commissioned surgery for patients requiring patellar resurfacing or replacement and funding approval for this procedure is not normally needed where patients meet the criteria within this policy.

Tri- compartmental knee surgery under the HRG code **"HR05Z Reconstruction Procedures Category 2"** is not routinely funded and clinicians should apply for individual funding approval setting out why the patient is unable to access the commissioned treatment and how they will benefit over and above all other patients for whom this treatment is also not available.

Exclusions:

Patient-specific Custom Knee Prosthesis

This is a more recent advance in knee replacement surgery. A guide is created using magnetic resonance imaging (MRI) scans. This helps to create the best fitting technique for each individual patient's implant. However, there is limited evidence that these benefit patients more than standard prostheses therefore custom knee prosthesis are not routinely funded.

Hyaluronan Acid Injections
Intra-articular Hyaluronan injections are not commissioned for the treatment of knee pain or OA.

NOTE

If the patient in question is clinically exceptional compared to the cohort, then an Exceptional Funding Application may be appropriate. The only time when an EFR application should be submitted is when there is a strong argument for clinical exceptionality to be made. EFR applications will only be considered where evidence of clinical exceptionality is provided within the case history/primary care notes in conjunction with a fully populated EFR application form.

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.

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 between thirty minutes to an 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?

Pain / Functional Impairment	Minor	Moderate	Severe
Slight	Manage Conservatively in Primary Care – do not refer without funding approval	Manage Conservatively in Primary Care – do not refer without funding approval	Consider a referral to MSK for further conservative management and advice MSK to manage conservatively
Moderate	Manage Conservatively in Primary Care – do not refer without funding approval	Manage Conservatively in Primary Care – do not refer without funding approval	Consider a referral to MSK for further conservative management and advice MSK to manage conservatively
Intense	Consider a referral to MSK for further conservative management and advice MSK to manage conservatively	MSK Review and where appropriate referral to Secondary Care	MSK Review and where appropriate referral to Secondary Care
Severe	Consider a referral to MSK for further conservative management and advice MSK to manage conservatively	MSK Review and where appropriate referral to Secondary Care	Consider referral immediately if risk of losing mobility

BRAN

For any health- related decision, it is important to consider "BRAN" which stands for:

- **B**enefits
- **R**isks
- **A**lternatives
- Do **N**othing

Benefits

Surgery can reduce pain and increase mobility in the affected area.

Risks

As with any operation, knee replacement surgery has risks and complications as well as benefits.
Complications occur in about one in 20 cases, but most are minor and can be successfully treated. Possible complications include:

- **Infection of the wound** – this will usually be treated with antibiotics, but occasionally the wound can become deeply infected and require further surgery. In rare cases it may require replacement of the artificial knee joint
- **Unexpected bleeding into the knee joint, ligament, artery or nerve damage in the area around the knee joint, blood clots or deep vein thrombosis (DVT)** – clots may form in the leg veins as a result of reduced movement in the leg during the first few weeks after surgery. They can be prevented by using special support stockings, starting to walk or exercise soon after surgery, and by using anticoagulant medicines
- **Fracture in the bone around the artificial joint during or after surgery** – treatment will depend on the location and extent of the fracture
- **Excess bone forming around the artificial knee joint and restricting movement of the knee** – further surgery may be able to remove this and restore movement
- **Excess scar tissue forming and restricting movement of the knee** – further surgery may be able to remove this and restore movement
- **The kneecap becoming dislocated** – surgery can usually repair this
- **Numbness in the area around the wound scar**
- **Allergic reaction** – you may have an allergic reaction to the bone cement if this is used in your procedure

In some cases, the new knee joint may not be completely stable and further surgery may be needed to correct it.

Alternatives

These may include lifestyle changes and some types of pain relief, such as:

- weight loss to reduce the strain on your knee if you're overweight
- low-impact exercise such as swimming, walking or cycling, and muscle strengthening in the knee – a physiotherapist may advise and support you with exercising
- using walking aids
- wearing special footwear or insoles for your shoes
- pain relief medicines, gels or creams
- hydrocortisone (steroid) injections – an injection into the knee joint to help with pain and swelling

Do Nothing

Remember, you always have the option to do nothing. Doing nothing is an equally reasonable option to doing something. Sometimes “not yet” is a good enough answer until you gather more information.

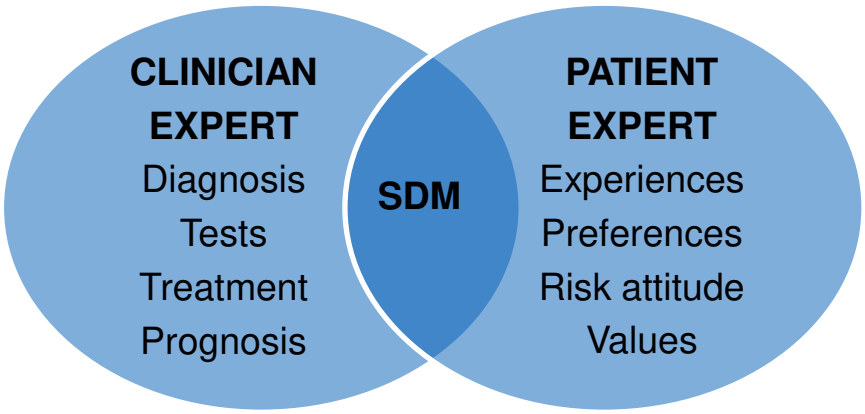
Knee replacement– Plain Language Summary

Knee replacement surgery involves replacing damaged parts of your knee joint with metal or plastic parts. It's most commonly used to treat pain and stiffness in the knee joint caused by osteoarthritis. It may be recommended if other treatments or lifestyle changes have not worked and knee pain is affecting a person’s daily life. Depending on the damage to the knee, it can be used to replace an entire knee joint (total knee replacement) or some of it (partial knee replacement).

Shared Decision Making

If a person fulfils the criteria for knee replacement it is important to have a partnership approach between the person and the clinician.

Shared Decision Making (SDM) is the meeting of minds of two types of experts:



It puts people at the centre of decisions about their own treatment and care and respects what is unique about them. It means that people receiving care and clinicians delivering care can understand what is important to the other person.

The person and their clinician may find it helpful to use 'Ask 3 Questions':

1. What are my options? (see sections above)
2. What are the pros and cons of each option for **me**?
3. How can I make sure that I have made the right decision?

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

1. National Health Service (2019) Health A to Z : Knee replacement www.nhs.uk/conditions.

Due regard

In carrying out their functions, the Bristol, North Somerset and South Gloucestershire Clinical Policy Review Group (CPRG) are committed to having due regard to the Public Sector Equality Duty (PSED). This applies to all the activities for which the ICBs are responsible, including policy development and review.

OPCS Procedure codes

Must have any of (primary only):

Procedures challenged in this policy:

OPCS Code:
W401,W402,W403,W404,W408,W409,W400,W411,W412,W413,W414,W418,W419,W410, W421,W422,W423,W424,W425,W426,W428,W429,W420

Relevant diagnoses for this policy:

ICD10 Code

Support

If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Customer Services Team on: **0117 900 2655** or **0800 073 0907** or email them on **BNSSG.customerservice@nhs.net.**

Document Control

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Governance

Commissioning policies are assessed for their likely level of impact on BNSSG ICB and the population for which it is responsible. This determines the appropriate level of sign off. The below described the approval route for each score category.

Policy Category	Approval By
Level 1	Commissioning Policy Review Group.
Level 2	Chief Medical Officer, or Chief Nursing Officer, or System Executive Group Chair
Level 3	ICB Board