Policy statement:	**Hip Joint Replacement**
Status:	**Group Prior Approval**

M&SECCGs commission surgery for hip joint replacement on a restricted basis as defined overleaf.

Referral to secondary care for consideration of elective hip joint replacement should only be made when there is clinically significant functional limitation resulting in significant diminished quality of life and management of other pre-existing medical conditions has been optimised, and, except for patients with severe functional limitation (as defined in table below), an extended course (at least 6 months) of non-surgical management to manage moderate to severe persistent pain has been exhausted and failed. This will include weight reduction and changing activity -which NICE considers core treatments, use of NSAIDs and other analgesics, and introducing a walking aid. There must be radiological features of joint damage and a narrowing of the joint space on radiograph.

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The Oxford Hip Score must be completed in Primary Care prior to referral for consideration of surgical hip joint replacement. The completed tool in full (not just the score) should be attached to the referral. The tool can be found at http://www.orthopaedicscore.com/scorepages/oxford_hip_score.html

The Oxford Hip Score tool should be used in conjunction with other information to help a patient make an informed decision as whether to proceed to surgery or not. This, together with the Shared Decision Making leaflet - **Deciding what to do about osteoarthritis of the hip-,** should form the basis for this discussion between GP / triage referral service and patient.

HipRelacementShare dDecisionAid.pdf

The patient must be willing to have surgery and, if relevant, had any risks associated with smoking or obesity explained to them. This must be discussed this with the patient before referring for surgical opinion for surgery.

Grading for the Oxford Hip Score

0 -19 May indicate severe hip arthritis. It is likely that some form of surgical intervention is required. Offer referral to a consultant orthopaedic surgeon for consideration of surgery.

20 - 29 May indicate moderate to severe hip arthritis. Consider seeking advice and guidance from consultant orthopaedic surgeon.

30 - 39 May indicate mild to moderate hip arthritis. Patients may benefit from non-surgical treatment, such as exercise, weight loss, and /or anti-inflammatory medication.

40 – 48 May indicate satisfactory joint function. May not require any formal treatment

M&SECCGs will only fund hip joint replacement surgery if:

- The patient complains of **severe** joint pain* **AND** has radiological features of **severe** disease including a narrowing of the joint space on radiograph **AND** has **severe** functional limitation* irrespective of whether non-surgical treatments* have been trialled,

OR

- The patient complains of **severe** joint pain* **AND** has radiological features of **severe** disease including a narrowing of the joint space on radiograph **AND** has **moderate** functional limitation*, despite the use of non-surgical treatments* such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.

OR

- The patient complains of **moderate** joint pain* **AND** has radiological features of **severe** disease including a narrowing of the joint space on radiograph **AND** has **severe** functional limitation*, despite the use of non-surgical treatments* such as adequate doses of NSAID analgesia, weight control treatments and physical therapies **AND** is **assessed to be at low surgical risk**. Surgical risk divided into; Low (ASA 1 to 3); High (ASA 4)

*****Please refer to the tables defining appropriate non-surgical treatments and the classification of pain levels and functional limitations to comply with policy.

In all cases:-

- Shared decision making must take place with respect to all management. This includes presenting the patient with information on all treatment options, and a clear description of the risks and benefits of each treatment, including surgery where indicated. Emphasis should be on dialogue enabling patients' to realise they have a choice, understand the options available to them, and make a decision as to which option to choose.

- Evidence that the patient has been fully involved in the decision to have joint surgery, and including evidence of shared decision making i.e. a full record of the discussion with the patient in their notes, and including risk/benefits of all treatment options offered.

- There must be documented supporting clinical diagnostics and other assessments to support the decision to perform joint surgery.

Prostheses for total hip replacement are recommended as a treatment option for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years.

Evidence suggests that the following patients would be INAPPROPRIATE candidates for hip joint replacement surgery and will therefore **not be funded:**

- Where the patient complains of mild joint pain **AND** has minor or moderate functional limitation
- Where the patient complains of moderate to severe joint pain **AND** has minor functional limitation **AND** has not previously had an adequate trial of conservative management as described above

Patients who are inappropriate for hip joint replacement surgery must not be listed for surgery and will not be funded.

Hip Replacement - Classification of Pain Levels and Functional Limitations

Variable	Definition
Pain Level	
Mild	Pain interferes minimally on an intermittent basis with normal activities of daily living. Not related to rest or sleep. Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin/paracetamol at regular doses.
Moderate	Pain occurs daily with movement and interferes with normal activities of daily living. Vigorous activities cannot be performed. Not related to rest or sleep. Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin/paracetamol at regular doses
Severe	**Pain is constant and interferes with most normal activities of daily living. Pain at rest or interferes with sleep. Pain not controlled, even by narcotic analgesics.**
Previous non-surgical treatments	
Correctly Done	**NSAIDs, paracetamol, aspirin or narcotic analgesics at regular doses over a period of at least 6 months without achieving management of pain; provision of weight management advice and support if overweight with patient engagement, physical therapies done.**
Incorrectly Done	NSAIDs, paracetamol, aspirin or narcotic analgesics at regular doses over a period of less than 6 months without achieving management of pain; no provision of weight management advice and support if overweight with or without patient engagement, no physical therapies done**.**
Functional Limitations	
Minor	Functional capacity adequate to conduct normal activities of daily living 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 of daily living and self-care. Walking capacity of about one half hour. Aids such as a cane are needed.
Severe	**Largely or wholly incapacitated. The quality of life is significantly compromised.** **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.**

M&SECCGs commission Primary Hip Replacements based on good clinical practice pathways as identified by the British Orthopaedic Association and Monitor[1].

The CCGs commission Hip replacement in line with the British Orthopaedic Association good practice pathway:

British Orthopaedic Association good practice pathway for primary total knee replacements.

Defined as

- a first outpatient appointment,

- a follow-up outpatient appointment,
- an inpatient admission and
- two outpatient follow-up appointments maximum only.

Further long term routine ongoing follow up is considered to be a **low clinical priority** and not funded.

Funding for patients not meeting the above criteria will only be granted in clinically exceptional circumstances.

Individual funding requests should only be made where the patient demonstrates clinical exceptionality.

Further information on applying for funding in exceptional clinical circumstances can be found on the CCGs' website.

Procedure	**OPCS4 codes**
Primary total hip replacement with or without cement	W3712 W371 , W379 , W381 , W389, W391, W399, W931, W939, W941, W949, W951, W959
Total prosthetic replacement of the hip, with or without cement, bilateral	All above codes with Z941 As in primary hip replacement with code Z941 for bilateral operations
Complex primary total hip replacement (including bone grafting or femoral osteotomy)	W3713

OPCS codes	WF01A, WF02A. Treatment function code 330.

References:

NICE CG177 Osteoarthritis: care and management
https://www.nice.org.uk/guidance/cg177

British Orthopaedic Association-2017 Commissioning Guide: Pain Arising from the Hip in Adults

https://www.boa.ac.uk/wp-content/uploads/2017/11/Pain-Arising-from-the-Hip-Guide-Final.pdf