West Yorkshire & Harrogate
Joint Committee of Clinical Commissioning Groups

Summary report			
Date of meeting: 14 January 2020		Agenda item: 71/20	
Report title:	**Elective Care and Standardisation: Hip Policies for review and recommendation**		
Joint Committee sponsor:	Matt Walsh		
Clinical Lead:	Dr James Thomas		
Author:	Catherine Thompson, Programme Director		
Presenter:	Dr James Thomas		
Purpose of report: (why is this being brought to the Committee?)			
Decision	✓	Comment	
Assurance	✓		
Executive summary			
The West Yorkshire and Harrogate (WY&H) Elective Care and Standardisation of Commissioning policies programme addresses clinical thresholds and criteria for clinical procedures, as well as efficient prescribing. The purpose of the clinical thresholds workstream is to review and standardise the clinical thresholds for these procedures across the nine Clinical Commissioning Groups of WY&H. We present here a hip arthroplasty policy and a hip arthroscopy policy for adoption across WY&H.			
Recommendations and next steps			
The Joint Committee is asked to: • agree the hip replacement and hip arthroscopy policies			
Delivering outcomes: describe how the report supports the delivery of STP outcomes			
Health and Wellbeing: The programme adopts a 'right care, right place, right time' approach to the planning and delivery of planned care services. **Care and Quality:** The clinical thresholds and criteria are for procedures which provide benefit to only a limited number of people, or which should only be offered after other treatment options have been tried. Introducing this policy will ensure that only the people who will benefit from these procedures are offered them. Adoption across West Yorkshire and Harrogate will reduce the variation in treatment offered to people across our region. **Finance and Efficiency:** The financial impact of the hip replacement and hip arthroscopy policies will vary between places but we do not anticipate any significant change in costs across the WY&H HCP			
Impact assessment (please provide a brief description, or refer to the main body of the report)			
Clinical outcomes:	See paragraphs 12 and 16 and appendices 3 and 4		
Public involvement:	See paragraph 8 to 12		

Finance:	See paragraph 18 to 23
Risk:	See paragraph 13 to 16 and appendices 2 and 6
Conflicts of interest:	Dr James Thomas: GP Chair of NHS Airedale, Wharfedale and Craven CCG; partner of Modality GP partnership; Dr Kate Thomas (spouse) is also a partner of Modality GP partnership. Dr Matt Walsh: Chief Officer of NHS Calderdale CCG Catherine Thompson: none declared

Elective Care and Standardisation of Commissioning Policies Programme: Hip Policies (proposal) for review and recommendation

Introduction

1. The West Yorkshire and Harrogate Elective Care and Standardisation of Commissioning policies programme addresses clinical thresholds and criteria for clinical procedures, including standardisation of clinical pathways. The purpose of the clinical thresholds workstream is to review and standardise the clinical thresholds for these policies across the nine Clinical Commissioning Groups of West Yorkshire and Harrogate (WY&H). This will reduce variation in access to care across WY&H and ensure that care is evidence based.

2. The Elective Care and Standardisation of Commissioning Policies (SCP) programme of the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) has considered the hip surgery policies across WY&H and developed a single set of policies from these. The WY&H Elective Care and SCP programme recommends the adoption of these policies across all CCGs within WY&H. The policies are presented here for consideration and decision by Joint Committee.

West Yorkshire and Harrogate Policy Development Process

3. The Elective Care and SCP programme has developed a governance process to support decision making through the Joint Committee of WY&H CCGs as set out in the scheme of delegation appended to the WY&H Memorandum of Understanding. This has been discussed during presentations of the Elective Care and SCP programme at the WY&H Clinical Forum and Joint Committee meetings and agreed as an acceptable approach. The process is detailed here for clarity. See also the governance diagram at Appendix 1, which provides additional detail e.g. specific working groups.

   - Each policy or pathway is developed in the relevant working group using the 'do once and share' approach i.e. one place / CCG leads the development of the policy or pathway.
   - Clinical involvement is secured by the place leading the pathway / policy development, and the draft policy / pathway shared for comment and development with relevant clinicians across WY&H. Amendments are made in response to clinical feedback to reach a consensus position.
   - The developed policy or pathway is shared with members of the working group to ensure agreement of all working group members.
   - Mapping of the differences between the proposed pathway and the current pathway and policies in each of the nine WY&H CCGs and an assessment of issues and risks[1].
   - Mapping of engagement findings from across the nine WY&H CCGs and assessment of the need for consultation or further engagement
   - Completion of the WY&H Quality and Equalities Impact Assessment (agreed at the January 2019 Joint Committee)
   - The policy or pathway is presented at the Elective Care and SCP programme board to ensure representation and agreement from all nine CCGs within WY&H prior to recommendation to the Joint Committee.

[1] This document can found in full at Appendix 2.

- Development and discussion at Joint Committee and/ or Clinical Forum
- Decision at Joint Committee

West Yorkshire and Harrogate Policies for Consideration

4. Osteoarthritis (OA) of the hip is a common problem affecting older people, as a result of 'wear and tear' in the hip joint. Most people will be able to manage their symptoms with lifestyle modifications and non-surgical treatment approaches. In some people the OA will progress and the patient will benefit from hip replacement surgery (hip arthroplasty).

5. Hip impingement syndrome is caused by abnormal contact between the top of the thigh bone (femur) and the hip socket (acetabulum). The symptoms usually affect young, active people and can usually be managed by lifestyle changes and drug treatment. For some people who meet very specific criteria, arthroscopic (key-hole) surgery can provide benefit.

6. A labral tear of the hip is an injury of the hip labrum. This is a 'rim' of cartilage around the hip socket. A torn labrum can be caused by repetitive movements over time or by traumatic injury, typically during sporting activities such as running, football, hockey and tennis.

7. A WY&H policy for hip replacement for hip arthritis, and a policy for arthroscopic hip surgery (hip arthroscopy) have been developed which align to the MSK Pathway. The proposed policies are included in appendix 3 and 4, and the MSK pathway is included at Appendix 5.

Engagement and Consultation

8. The development of the hip policies was led by NHS Wakefield CCG and Mid Yorkshire Hospitals Trust with involvement from the clinical and managerial staff. A draft of the pathway was then shared with all the CCGs of WY&H, and through the West Yorkshire Association of Acute Trusts with all the acute NHS provider organisations. Each CCG also shared the pathway with local clinical staff and service providers as appropriate. Input and feedback was received through both face to face and electronic methods.

9. Advice was sought from the communications and engagement leads in each of the CCGs, asking them whether the changes that were proposed were of a nature that they would want to engage on locally. All replied that the changes were very minor, and should result in an improvement in service so they would not normally undertake local engagement. Local communication to provider organisations, clinicians and the local population will be necessary to support implementation.

10. At its meeting on 14 October 2019, the Joint Committee's Patient and Public Involvement (PPI) Assurance Group considered an update on the Elective Care Programme, including the approach taken by the clinical thresholds workstream regarding engagement on proposed regional pathways and policies. The group noted the reasons why local engagement had not been required and noted that communication and engagement would be necessary to support implementation. The group supported the approach to PPI of the Programme.

11. The WY&H Health and Care Partnership engagement mapping exercise[2] from March 2018 provided information to inform the development of the policies. The key findings were that:

- people felt that there should not be a postcode lottery for access to care
- consideration needs to be given to the effectiveness of treatments.

12. Creating a single set of hip policies for WY&H will help increase standardisation of services and reduce variation in access and availability of care. Ensuring the clinical thresholds for the hip policies are consistently applied will mean that procedures will only be carried out when they will be clinically effective.

Quality and Equality Impact Assessment

13. To support the governance processes for the Elective Care and SCP programme a single approach to Quality and Equality Impact Assessment (QEIA) has been developed by the WY&H CCG Chief Nurses, Quality Leads and Equality leads. This process, including a policy, document template and guidance notes were approved at the WY&H Joint Committee of CCGs in their public meeting on 8 January 2019.

14. The groups of people affected by this policy are :

- Older people (OA hip) and young people (hip impingement syndrome).
- Primary care staff, in particular, General Practitioners, as they will need to take account of these policies when assessing and referring patients.
- Community service and secondary care clinicians, in particular MSK staff who also need to take account of this pathway when treating patients and making onward referrals.

15. The QEIA for the hip policies identified no negative impacts from implementing these policies. Positive impacts for patient experience, safety, clinical effectiveness and workforce were identified. The QEIA summary is included at Appendix 6.

16. A key consideration of Elective Care and SCP programme is equitable access to appropriate, evidence-based interventions. By implementing these policies and pathways, we aim to reduce variation of inequalities in health outcomes for the population of WY&H by systematically offering the most up-to-date clinically proven treatments and making the most effective use of NHS resources.

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[2] https://www.wyhpartnership.co.uk/application/files/3015/3797/5058/WYH_HCP_Engagement_mapping_-_March_2018_FINAL.pdf

Impact of Implementation in West Yorkshire and Harrogate

17. Mapping of the differences between the proposed policy and the current policy in each of the nine WY&H CCG's is included in Appendix 2.

Hip Replacement

18. Implementation of the hip replacement policy will simplify the administrative processes and clinical decision making for orthopaedic surgeons and provider organisations as the clinical thresholds will be standardised across all CCGs in WY&H.

19. The emphasis on shared decision making and supported self-management will require additional staff development to ensure all clinical staff within MSK and elective orthopaedic services have the required skills for this approach.

20. There may be some limited reduction in hip replacement procedures. We know from the Hip Equity audit that there is significant variation in access to hip replacement surgery at Place and although standardisation of commissioning thresholds will reduce some variation, it will not reduce all. Some commentators suggest a reduction of up to 15% of surgical procedures following a shared decision making conversation. We are not confident that this magnitude will be achieved, particularly in the first year, and expect the short term financial impact to be neutral. Activity data for hip replacement data can be found at Appendix 7.

Hip Arthroscopy

21. Implementation of the hip arthroscopy policy will simplify the administrative processes and clinical decision making for orthopaedic surgeons and provider organisations as the clinical thresholds will be standardised across all CCGs in WY&H.

22. The emphasis on shared decision making and supported self-management will require additional staff development to ensure all clinical staff within MSK and elective orthopaedic services have the required skills for this approach.

23. We anticipate the overall financial impact of the hip arthroscopy policy to be neutral. We currently perform approximately 45 Hip Arthroscopies each year which are delivered by two surgeons, one in Harrogate and one in Leeds. We do not have sufficient demand to expand beyond this level of provision at this point in time. Activity data can be found in Appendix 7.

Implementation Plans

24. The nine CCGs of WY&H have previously agreed a 12 month timescale for the implementation of new policies. This reflects the contract negotiation process with service providers.

25. Implementation of the WY&H hips policies should be monitored by regular local audit of clinical practice and patient experience.

Summary and Recommendations

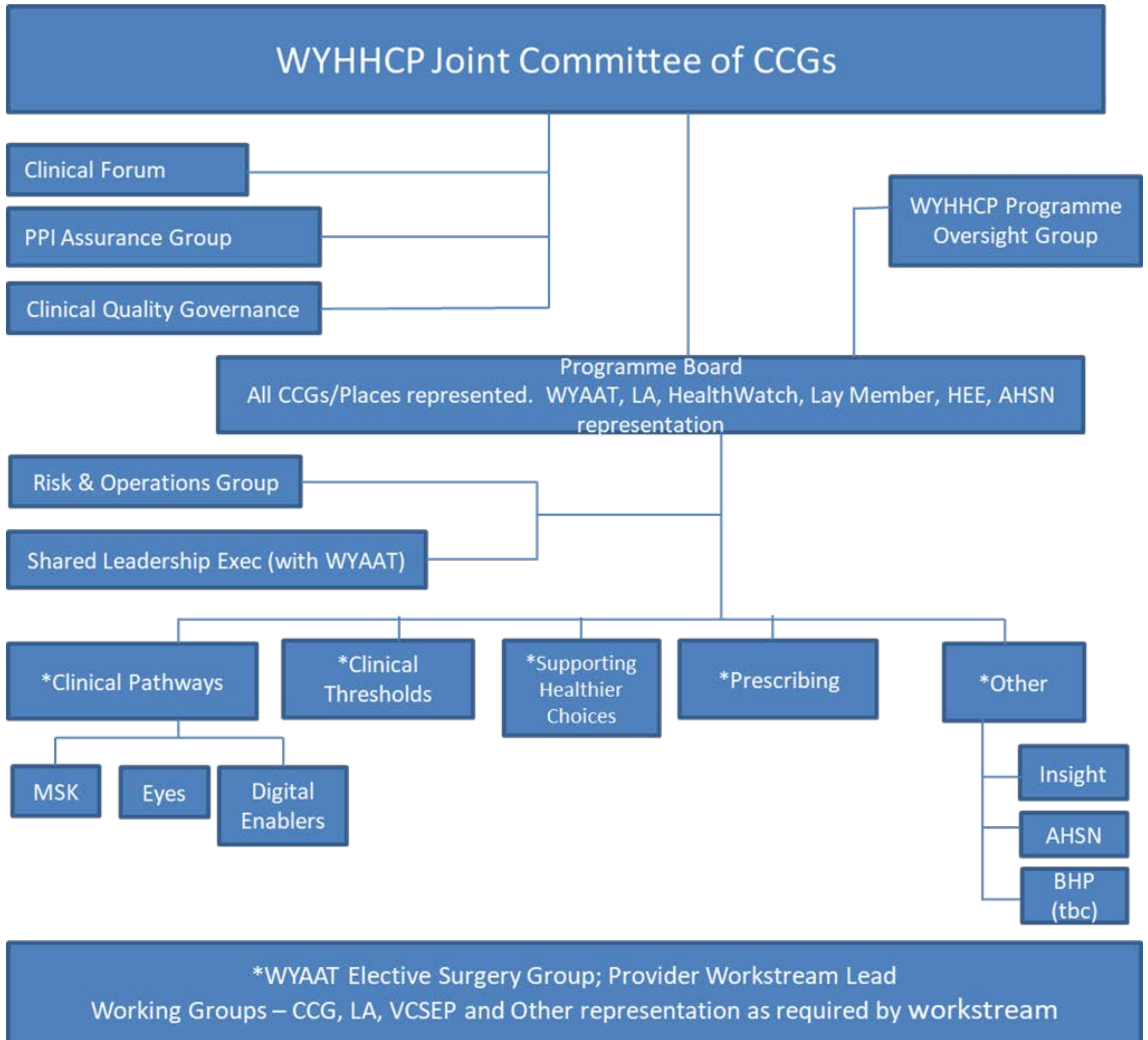
26. The WY&H Joint Committee of CCGs is asked to adopt:

    a) the proposed policy for hip replacement for hip arthritis, and
    b) the proposed policy for hip arthroscopy.

List of Appendices:

1. **Governance Structure**
2. **Mapping and Gapping**
3. **WY&H policy for hip replacement for hip arthritis**
4. **WY&H policy for hip arthroscopy.**
5. **MSK Pathway.**
6. **Quality and Equality Impact Assessment**
7. **Hip surgery activity data.**

Appendix 1: Governance Structure



Clinical Speciality/threshold	Leeds	Wakefield	Calderdale, Gr Huddersfield & N. Kirklees	Bradford	Airedale, Wharfedale and Craven	Harrogate
Hip Arthroscopy **This commissioning statement refers to:** Arthroscopic Hip Surgery for children and adults for: Femero-acetabular impingement Labral tears	No change to threshold	No change to threshold	No change to threshold	No change to threshold	No change to threshold	No change to threshold
Policy Exclusions Patients with advanced / severe degenerative OA on a preoperative X-ray • Patients who have hip dysplasia or considerable protrusion unless they have mechanical symptoms • Patients with Osteonecrosis with femoral head collapse • Patients with joint ankyloses	Minor reduction	Minor reduction	Minor reduction	Minor reduction	Minor reduction	No change to threshold
Policy Inclusion Criteria The commissioning of hip arthroscopy (from surgeons with specialist expertise in this type of surgery) is in line with the requirements stipulated by NICE IPG 408 (https://www.nice.org.uk/guidance/ipg408). **Details of all patients undergoing this procedure should be entered into a register established by the British Hip Society[3].** The	No change to threshold	No change to threshold	No change to threshold	No change to threshold	No change to threshold	No change to threshold

[3] The onus should be placed on all providers of NHS funded hip arthroscopy to support the collection of this data, establishing effective processes as required.

Clinical Speciality/threshold	Leeds	Wakefield	Calderdale, Gr Huddersfield & N. Kirklees	Bradford	Airedale, Wharfedale and Craven	Harrogate
current evidence and guidance supports referral of patients with following conditions to the hospital services and **only for patients who fulfil of the following criteria:**						
Diagnostic and Imaging Requirements AP X-Ray of pelvis with marker ball and lateral hip X-Ray of affected side • Reporting requirements MRI **OR** arthrogram • MRI scans should not be requested by primary care • Reporting requirements	No change to threshold	No change to threshold	No change to threshold	No change to threshold	No change to threshold	No change to threshold
Hip Replacement Arthritis **Commissioning statement refers to:** Hip replacement for Hip Arthritis	No change to threshold	No change to threshold	No change to threshold	No change to threshold	No change to threshold	No change to threshold
Policy Exclusions This policy does not apply to children. Evidence suggests that the following patients would be INAPPROPRIATE candidates for hip joint replacement surgery: 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 not previously had an adequate trial of conservative management as described above. Patients whom are assessed by the above criteria to be inappropriate for hip replacement surgery should not be listed for surgery.	No change to threshold	No change to threshold	No change to threshold	No change to threshold	No change to threshold	No change to threshold

Clinical Speciality/threshold	Leeds	Wakefield	Calderdale, Gr Huddersfield & N. Kirklees	Bradford	Airedale, Wharfedale and Craven	Harrogate
Policy Inclusion Criteria People who are obese should be encouraged to undertake a weight management programme and/or exercise programme to support optimal post-operative outcomes	Improvement to threshold	Improvement to threshold	Improvement to threshold	Improvement to threshold	Improvement to threshold	Improvement to threshold
Referrals should be made if any one of the following applies: The patient complains of intense or severe symptomatology Has radiological features of severe disease or bone loss Has radiologic features of moderate disease; and is troubled by limited mobility or stability of the hip joint Has pain or functional limitations and is troubled by limited mobility or stability of the hip joint 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.	Minor reduction	Minor reduction	Minor reduction	Minor reduction	Minor reduction	Minor reduction
NICE Guidance: https://www.nice.org.uk/guidance/cg189/chapter/1-Recommendations#identification-and-classification-of-overweight-and-obesity **The Oxford Pain Score tool can be found at:** http://www.orthopaedicscore.com/scorepages/oxford_hip_score.html	No change	No change	No change	No change	No change	No change

Clinical Speciality/threshold	Leeds	Wakefield	Calderdale, Gr Huddersfield & N. Kirklees	Bradford	Airedale, Wharfedale and Craven	Harrogate
Further guidance available at: http://www.bjj.boneandjoint.org.uk/content/89-B/8/1010.full						

West Yorkshire and Harrogate Health and Care Partnership					
Policy	**Hip Replacement for Hip Arthritis**			**X CCG Ref**	
First Issue Date		**Current version:**		**Last reviewed:**	
Review date		**Contact**			
Clinical Reviewer		**Approved by**			
Referral ?					

Summary of Intervention

A lot of people with hip osteoarthritis do not require joint surgery and can adequately manage their symptoms with compliance to a comprehensive non-surgical programme including appropriate use of analgesia, lifestyle modification, weight reduction and exercise therapy.

Clinicians with responsibility for referring a person with osteoarthritis for consideration of joint surgery, should ensure that the person has been offered the recommended non-surgical treatment options (NICE CG177) and meet the criteria listed in this policy.

Patients who have persistent or progressive symptoms, despite comprehensive non-operative management and good patient engagement and participation in therapy programmes, should share in the decision for referral for surgical assessment. This should include:

- **Confirmation of willingness to undergo surgery**
- **The benefits and risks of surgery**
- **The potential consequences of not having surgery**
- **Recovery timescales and rehabilitation requirements after surgery**

Policy Exclusions

This policy does not apply to:

- Children under 16
- Hip replacements required due to acute trauma
- Cancer

Commissioning Threshold

Referrals for surgical opinion should be made if patients present with one of the following:

- Patient complains of intense or severe pain (please refer to the classification of symptomology table below)

OR

- Patient has radiological features of severe degenerative change or bone loss

OR

- Patients who have demonstrated good compliance to a comprehensive non-operative programme including NSAID's and analgesics, weight reduction, lifestyle modification and participation in therapy programmes

AND

continue to present with moderate symptoms (please refer to the classification of symptomology table below)

Classification of pain levels and functional limitations are described in the table below:

For Hip Replacement: Classification of Symptoms

Variable	Definition
Mild	Sporadic pain. Able to to carry out daily activities (those requiring great physical activity may be limited). Analgesia medication controls pain with no/few side effects.
Moderate	Occasional pain. Pain walking on level surfaces (half an hour, or standing). Some limitation of daily activities. Analgesia medication controls pain with no/few side effects.
Intense	Pain of almost continuous nature. Pain walking short distances on level surfaces or standing for less than half an hour. Daily activities significantly limited. Continuous use of analgesia medication to take effect. Requires the sporadic use of walking aid
Severe	Continuous pain. Pain at rest. Daily activities significantly limited constantly. Continuous use of analgesia medication with adverse effects or poor response. Requires more constant use of walking aid Rapid joint deformity / leg shortening

Oxford Hip Score

The Oxford hip score provides a single summed score which reflects the severity of problems that the respondent has with their hip and can be used when considering referral.

It may help a clinician assess the severity of this hip disease but should not be used as an arbitrary threshold. A score below 20 may indicate severe hip arthritis and it is highly likely that these patients may well require some form of surgical intervention and therefore may benefit from a surgical opinion.

The tool may be used as part of a shared decision making conversation.
The Oxford Knee Score can be found at:
http://www.orthopaedicscore.com/scorepages/oxford_knee_score.html
Further guidance available at:
http://www.bjj.boneandjoint.org.uk/content/89-B/8/1010.full

Conservative Management

- Patients with hip pain, and without red flag or acute trauma indications, should be

managed in line with the WY&H MSK pathway (see appendix 5) and should not normally be referred for surgical opinion before all appropriate non-surgical management options have been tried and have not been effective or are judged likely to be ineffective.

- Referral should be when other pre-existing medical conditions have been optimised AND conservative measures have been exhausted / failed.
- Conservative measures include weight reduction, analgesia, education on OA and the management of symptoms, referral to physiotherapy if required, lifestyle modification such as increased physical activity, exercise, and introducing a walking aid.
- Patients who are symptomatically better or who are improving with non-surgical management should not usually be referred for surgical assessment.

Shared Decision Making

- Patients who have persistent or progressive symptoms, despite comprehensive non-operative management and good patient engagement and participation in therapy programmes, should have a shared decision making conversation to consider referral for surgical assessment. The Oxford Hip Score may be referred to in Shared Decision Making discussions with patients as a measure of severity.
- This should include an understanding of rehabilitation requirements and likely duration and confirmation of willingness to undergo surgery. .
- The evidence for risks, benefits and differences in outcomes between surgical intervention and continued non-operative management should be included in this conversation, with a discussion of the patient's treatment / outcome goals.
- The patient and the clinician should reach a shared decision whether to proceed with referral / surgical intervention.

Lifestyle Factors

- All patients being referred for hip pain should have an assessment of their BMI and smoking status, as well as other 'lifestyle factors' that may influence their long term health outcomes, as part of a 'making every contact count' approach to providing health care services.
- All patients who would benefit from a health improvement intervention to address weight management, smoking or other factors should be made a meaningful offer of support for this at appropriate stages in their conservative management and in all instances before referral is made for surgical assessment.
- Patients with a BMI of >40 (the super-obese) are at increased risk of surgical complications and careful consideration should be given for surgery
- If there are specific indications where delay would increase bone loss and prolong suffering, the an individual decision should be made by the clinician, with the patient, balancing the clinical risk against the perceived benefits.

Summary of evidence / Rationale	Osteoarthritis may not be progressive and a proportion of patients will not need surgery with their symptoms adequately controlled by non-surgical measures as outlined by NICE[3]. Symptoms progress in 15% of patients with hip pain within 3 years and 28% within 6 years[8]. 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 patients 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[9]. 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, ischemic heart disease (IHD), hypertension (HT) and sleep apnoea. Some years ago, an Arthritis Research Campaign Report[7] stated that joint surgery is less successful in obese patients because: • Obese patients have a significantly higher risk of a range of short-term complications during and immediately after surgery (e.g. longer operations, excess blood loss requiring transfusions, deep vein thrombosis (DVT) and wound complications including infection). • The heavier the patient, the less likely it is that surgery will bring about an improvement in symptoms (e.g. they are less likely to regain normal functioning or reduction in pain and stiffness). • The implant is likely to fail more quickly, requiring further surgery (e.g. within 7 years, obese patients are more than ten times as likely to have an implant failure). • 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 recent extensive literature review advises assessment of "timely weight loss as a part of conservative care"[12]. 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.
Reference	1. NHS Vale of York Clinical Commissioning Group - Prevention and Better Health Strategy http://www.valeofyorkccg.nhs.uk/data/uploads/governing-body-papers/1-september-2016/item-7.1-prevention-and-better-health-strategy.pdf 2. 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- 3. Optimising Outcomes from Elective Surgery Commissioning Statement Statement number: 01(link when PDF done) 4. Obesity prevention NICE CG 43 Dec 2006; last amended March 2015 https://www.nice.org.uk/guidance/cg43 5. RightCare shared decision-making tools

	6. NHS Choices: http://www.nhs.uk/chq/Pages/849.aspx?CategoryID=51&SubCategoryID=165 7. 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 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 9. Public and patient guide to the NJRs 14th annual report 2017. Hip replacement edition (2018) http://www.njrcentre.org.uk/njrcentre/Portals/0/Documents/England/PPG/09736%20NJR%20PPG%20-%20HIPS%202018%20WEB%20SPREADS.pdf?ver=2018-02-08-112731-437 10. British Orthopaedic Association (2017) Commissioning Guide: Pain Arising from the Hip in Adults https://www.boa.ac.uk/uploads/assets/2a2182ef-979a-447b-95f671b7e73e15a9/pain%20arising%20from%20the%20hip%20guide.pdf

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<tr><th colspan="6">West Yorkshire and Harrogate Health and Care Partnership</th></tr>
<tr><td>Policy</td><td colspan="3">Hip Arthroscopy</td><td>X CCG Ref</td><td></td></tr>
<tr><td>First Issue Date</td><td></td><td>Current version:</td><td></td><td>Last reviewed:</td><td></td></tr>
<tr><td>Review date</td><td></td><td>Contact</td><td colspan="3"></td></tr>
<tr><td>Clinical Reviewer</td><td></td><td>Approved by</td><td colspan="3"></td></tr>
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Summary of Policy

- **This commissioning statement refers to:**
  - Arthroscopic Hip Surgery for children and adults for:
    - Femero-acetabular impingement
    - Labral tears

Policy Exclusions

- Patients with advanced / severe degenerative OA on a preoperative X-ray
- Patients who have hip dysplasia or considerable protrusion unless they have mechanical symptoms
- Patients with Osteonecrosis with femoral head collapse
- Patients with joint ankyloses

Policy Inclusion Criteria

The commissioning of hip arthroscopy (from surgeons with specialist expertise in this type of surgery) is in line with the requirements stipulated by NICE IPG 408 (https://www.nice.org.uk/guidance/ipg408). **Details of all patients undergoing this procedure should be entered into a register established by the British Hip Society[4].** The current evidence and guidance supports referral of patients with following conditions to the hospital services and **only for patients who fulfil all of the following criteria:**

- Diagnosis of definite labral pathology and/or hip impingement syndrome and/or other conditions where a minimally invasive approach is preferred as defined through clinical and radiological investigation (e.g. X-rays, MRI, CT scans) **AND**
- A surgeon with specialist expertise in hip arthroscopy has confirmed the diagnosis, which should include imaging reported by a specialist musculo-skeletal radiologist, **AND**
- Severe symptoms with compromised function measured by objective scoring tools and with a duration of at least six months where diagnosis has been made **AND**
- Failure to respond to conservative treatment including activity modification, comprehensive physiotherapy with review by advanced practice physiotherapist, and drug therapy (non-steroidal anti-inflammatory drugs and paracetamol) for a period of 3 months.
- Intra-articular injection (steroid / anaesthetic) is recommended for diagnostic clarity or to support further, effective conservative management. This should be image guided in a specialist practice setting.
- Patients under the age of 16 or over the age of 50 should only proceed to surgery

[4] The onus should be placed on all providers of NHS funded hip arthroscopy to support the collection of this data, establishing effective processes as required.

after a wider multidisciplinary team discussion.

Conservative Management

- Patients with hip pain, and without red flag or acute trauma indications, should be managed in line with the WY&H MSK pathway (see appendix 5) and should not normally be referred for surgical opinion before all appropriate non-surgical management options have been tried and have not been effective.
- Patients who are symptomatically better or who are improving with non-surgical management should not usually be referred for surgical assessment.
- Patients with persistent pain which is not amenable to surgical intervention should be considered for referral to pain management services.

Lifestyle Factors

- All patients being referred for hip pain should have an assessment of their BMI and smoking status, as well as other 'lifestyle factors' that may influence their long term health outcomes, as part of a 'making every contact count' approach to providing health care services.
- All patients who would benefit from a health improvement intervention to address weight management, smoking or other factors should be made a meaningful offer of support for this at appropriate stages in their conservative management and in all instances before referral is made for surgical assessment.

Shared Decision Making

- Patients who have persistent or progressive symptoms, despite comprehensive non-operative management and good patient engagement and participation in therapy programmes, should have a shared decision making conversation to consider referral for surgical assessment. This should include an understanding of rehabilitation requirements and likely duration. The evidence for risks, benefits and differences in outcomes between surgical intervention and continued non-operative management should be included in this conversation, with a discussion of the patient's treatment / outcome goals. The patient and the clinician should reach a shared decision whether to proceed with referral / surgical intervention.

Diagnostic and Imaging Requirements

- AP X-Ray of pelvis with marker ball. This should be done prior to referral for specialist assessment to exclude structural pathology.
- Lateral hip X-Ray of affected side
- Hip MRI **OR** arthrogram
  - MRI scans should not be requested by primary care, and should only be requested following specialist clinical assessment
  - MRI or MR arthrogram should be reported by and MSK specialist radiologist or reporting radiographer
  - Imaging technique will be determined by availability of 1.5T or 3T MRI
- Hip CT should only be requested following assessment by orthopaedic specialist or when the patient is not suitable for MRI

See also the 2013 commissioning guide for pain arising from the hip in adults from the British Hip Society, available at https://www.britishhipsociety.com/uploaded/Pain%20arising%20from%20the%20hip%20in%20adults_11Nov_formatted.pdf

Summary of evidence / Rationale	Hip impingement syndrome is caused by abnormal contact between the top of the thigh bone and the hip socket. This results in 'clicking' of the hip, limited movement and pain, which can be made worse when the hip is bent or after sitting for a long time. The condition may be caused by an unusually shaped thigh bone or hip socket and usually affects young, often active people. Hip impingement syndrome is usually managed by changes to lifestyle and drug treatment. **Rational for Surgical treatment of FAI/Labral Tears in Selected Patients** In patients non responsive to conservative measures, open or arthroscopic surgery for proven FAI / labral tears has been shown to produce short and medium term benefits in terms of pain management and functional improvement in the hip[1-5]. Evidence for reduction in progression to advanced hip osteoarthritis is speculative. **Rationale for Arthroscopic vs Open Surgical Treatment of FAI** No significant differences in outcome have been demonstrated between open and arthroscopic surgery for FAI. As the HRG Code costs are the same, but arthroscopic intervention is a day case procedure, requiring no excess bed day costs, and is associated with a faster patient recovery time, surgical FAI interventions should be arthroscopic for a quicker recovery and to minimise costs. **Rationale for Treatment in Specialist / High Volume Centres** The number of operations performed for FAI, particularly hip arthroscopy, has increased rapidly in recent years in the UK. Hip arthroscopy is technically demanding with a steep learning curve. It is also important to identify which patients are appropriate to select for surgery, to streamline their work-up and perioperative care, and in particular to fine-tune rehabilitation protocols to optimize outcomes for both rehabilitation and surgery. The studies that report good outcomes are reported by centres performing high volumes of operations, with a great deal of experience of managing young adult patients with FAI and other hip conditions, a sound knowledge of who not to operate on, technical skill and experience, and excellent physiotherapy expertise. Thus there is a strong argument to support the treatment of such patients in specialist high-volume centres, as this will provide optimum patient outcomes and maximum quality for the tax-payer. **Implications of Not Treating Young Adults with Hip Impingement** In addition to chronic hip pain at a young age and the loss of function therein, there is evidence that hip impingement is likely to lead to end-stage osteoarthritis[6-12], and may account for almost half of all patients undergoing total hip replacement. Patients with impingement tend to develop OA early, during their most productive

	years. Historically, the results of arthroplasty in young adults have been poor, due to loosening of components, or wear of the bearing surface, resulting in further revision procedures. Attempts to mitigate wear have not always been successful. Hip impingement is not a 'new condition', but rather one mechanism by which the joint becomes damaged, including the soft tissue, called the labrum. This has only been recently understood. Treatments are now developed that show symptomatic improvements in both short and medium-term[13-15]. Two large trials are ongoing to add to this evidence. No long term data on the effects of FAI surgery in preventing osteoarthritis or reductions in the need for total hip replacement are available.
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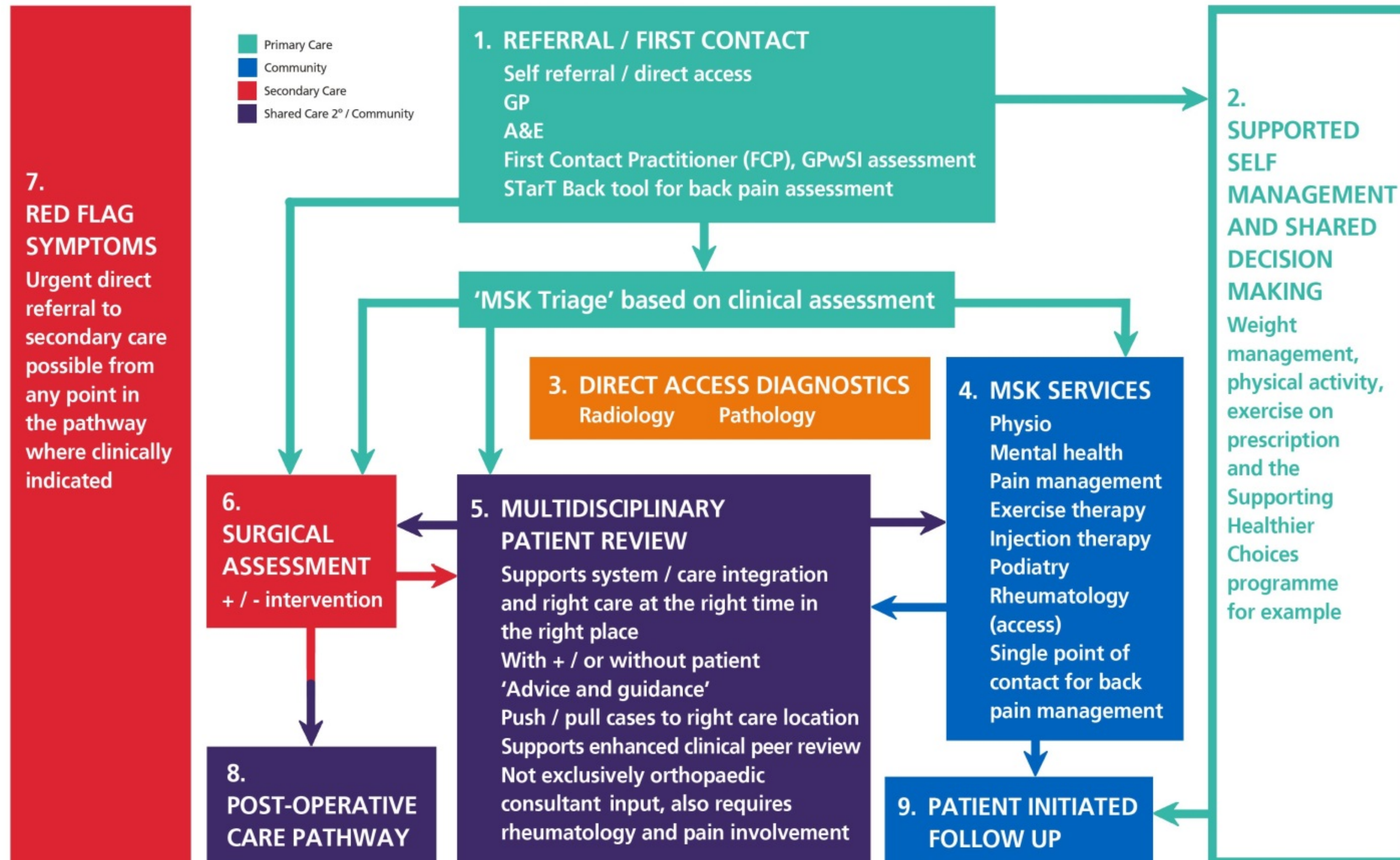
	Javaid MK, Judge A, Murray DW, Carr AJ, Arden NK, Glyn-Jones S. Subclinical deformities of the hip are significant predictors of radiographic osteoarthritis and joint replacement in women. A 20 year longitudinal cohort study. *Osteoarthritis Cartilage. 2014 Oct;22(10):1504-10.* 12. Nelson AE, Stiller JL, Shi XA, Leyland KM, Renner JB, Schwartz TA, Arden NK, Jordan JM. Measures of hip morphology are related to development of worsening radiographic hip osteoarthritis over 6 to 13 year follow-up: the Johnston County Osteoarthritis Project. *Osteoarthritis Cartilage. 2015 Oct 20. pii: S1063-4584(15)01357-6.* 13. Bedi A, Kelly BT, Khanduja V. Arthroscopic hip preservation surgery: current concepts and perspective. *Bone Joint J. 2013 Jan;95-B(1):10-9. doi:10.1302/0301-620X.95B1.29608. Review. PubMed PMID: 23307667.* 14. Imam S, Khanduja V. Current concepts in the diagnosis and management of femoroacetabular impingement. *Int Orthop. 2011 Oct;35(10):1427-35. doi: 10.1007/s00264-011-1278-7. Epub 2011 Jul 14. Review. PubMed PMID: 21755334; PubMed Central PMCID: PMC3174304.* 15. Khanduja V, Villar RN. The arthroscopic management of femoroacetabular impingement. *Knee Surg Sports Traumatol Arthrosc. 2007 Aug;15(8):1035-40. Epub 2007 May 30. PubMed PMID: 17534600.* 16. NICE IPG 408 (Sept 2011) Arthroscopic femoro-acetabular surgery for hip impingement syndrome http://guidance.nice.org.uk/IPG408 17. Vijay D Shetty, Richard N Villar. Hip arthroscopy: current concepts and review of literature. Br J Sports Med 2007; 41:64–68. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2658928/pdf/64.pdf 18. Macfarlane RJ, Haddad FS The diagnosis and management of femoroacetabular impingement. Annals of the Royal College of Surgeons of England, July 2010, vol./is. 92/5(363-7) http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3180305/pdf/rcse205-363.pdf 19. Ng V Y et al. Efficacy of Surgery for Femoro-acetabular Impingement: A Systematic Review. Am J Sports Med November 2010 38 2337-2345 http://www.ncbi.nlm.nih.gov/pubmed/20489213 20. Griffin DR et al (2016) The Warwick Agreement on femeroacetabular impingement syndrome (FAI syndrome): an international consensus statement; British Journal of Sports Medicine; 50: 1169-1176; https://bjsm.bmj.com/content/50/19/1169

Appendix 5: MSK Pathway



Quality and Equality Impact Assessment Appendix 6

West Yorkshire and Harrogate Health and Care Partnership

This summary sheet provides an overview of the staff involved, proposed change and a summary of the findings. This assessment consists of five domains: Patient Experience, Patient Safety, Effectiveness, Equality and Workforce.

Title of Scheme:	Hip Arthroplasty (Replacement) pathway and Hip Arthroscopy Pathway		
Project Lead:	Jo Rattray		
Clinical Lead:	James Thomas	Programme Lead:	Catherine Thompson
Senior Responsible Officer:	Matt Walsh	Date:	Sep-19

Proposed change:

Standardising the finer details of these policies ensures a consistent approach to their application across WY&H. It is proposed there is no weight limit identified however this will not superseed any CCG which has a broader 'Health Optimisation' policy in place. The Hip Replacement Pathway and the Hip Arthroscopy Pathway have been reviewed and standardised across the nine CCGs to create a single pathway for service design and delivery in each place, which draw together and harmonises the core components of the existing pathways from each of the nine CCGs of WY&H, and adds in the elements of best practice which are new recommendations in national guidance from NHS England, and local expert clinical opinion in WY&H.

Which areas are impacted?

Airedale, Wharfedale and Craven CCG	☑	Calderdale CCG	☑	Leeds CCG	☑
Bradford City CCG	☑	Greater Huddersfield CCG	☑	North Kirklees CCG	☑
Bradford Districts CCG	☑	Harrogate and Rural Districts CCG	☑	Wakefield CCG	☑

Summary of Impacts

Summary of findings:

The standardised pathway ensures a consistent approach to treatment across WY&H Health and Care Partnership. People will be supported to make better lifestyle choices and receive advice regarding exercise therapies. Consistency of care will lead to a positive impact on patient experience due to improved health outcomes. In certain areas at Place, patients will experience an enhancement following the implementation of the pathway. It's been identified that these positive impacts provide patient's with a greater sense of control through shared decision making and the inclusion of patient initiated follow-ups . Shared decision making will improve patient awareness and promote informed decision making and engagement in treatment programmes. Additional positive impacts are enhanced patient safety and clinical effectiveness as with the pathway and policies aligned to national guidance leading to the reduction in un-necessary procedures. Improved integration of services and new career development opportunities provide postive impacts for workforce. There may be an initial negative impact for patients who do not meet the threshold however mitigating factors such as the inclusion of shared decision making should reduce this. Alternative appropriate treatments will be offered, however initially increased access to exercise and smoking cessation services may lead to increased waiting times. Work needs to take place to increase the capacity in these areas. Minor impacts have been identified within the Equality section which relate to certain people having particular protected characteristics, such as people living in socio-economically deprived areas, or people who are are carers. In these situations mitigating actions have been identified regarding appropriate communication tools and accessibility of information. Where enhancement for patients has been identified in certain Places, this may lead to increased pressure on services and staff capacity in the locality.

Summary of Next Steps:

Work streams to implement and embed shared decision making skills and application at Place, and a review of treatment services and capacity. Work at Place should include a scoping of implications for workforce and plans should be implemented to reshape service where necessary. Further Communication resources and information guides should be sought and developed at Place where necessary to support patients and communities around their care and their choices.

Has this been incorporated into the project documentation?	**Yes**	

Appendix 7: Hip Arthroscopy and Hip Replacement data

Total Hip Replacement by CCG 2018/19

WY CCGs 2018/19	**Total Hip Replacement Activity**
NHS Leeds CCG	1047
NHS Wakefield CCG	519
NHS Bradford Districts CCG	401
NHS Greater Huddersfield CCG	343
NHS Calderdale CCG	337
NHS Harrogate and Rural District CCG	303
NHS Airedale Wharfedale and Craven CCG	287
NHS North Kirklees CCG	188
NHS Bradford City CCG	25
WEST Yorkshire & Harrogate	3450

Hip Arthroscopy by CCG

	Financial Year			
WY&H CCGS	**2015/16**	**2016/17**	**2017/18**	**2018/19**
NHS Airedale Wharfedale and Craven CCG	*	*	*	0
NHS Bradford City CCG	*	0	0	*
NHS Bradford Districts CCG	*	*	*	*
NHS Calderdale CCG	*	*	*	*
NHS Greater Huddersfield CCG	10	*	*	0
NHS Harrogate and Rural District CCG	*	6	0	*
NHS Leeds CCG	17	22	23	11
NHS North Kirklees CCG	*	*	*	0
NHS Wakefield CCG	*	*	10	*
West Yorkshire & Harrogate Total	48	43	44	22

*Figures lower than 6 are hidden as per NHS digital disclosure control