National variation between clinical commissioning groups in referral criteria for primary total hip replacement surgery

A Moorhouse, G Giddins

Royal United Hospital, Bath, UK

ABSTRACT

The referral criteria used by the UK clinical commissioning groups for primary total hip replacement surgery appear inconsistent; the criteria rarely follow National Institute for Health and Care Excellence criteria. With established guidelines available, it is unclear why the clinical commissioning groups have referral criteria with less evidence base, without obviously addressing particular issues in their locality.

KEYWORDS

Arthroplasty – Replacement – Hip – Referral

Accepted 14 January 2018

CORRESPONDENCE TO

Alexandra Moorhouse, E: alexandramoorhouse@nhs.net

Introduction

In recent years, the public focus on NHS spending has become greater than ever, with highly publicised budget cuts. This has coincided with an ageing, sicker population placing a greater demand on healthcare provision and testing the ability of clinical commissioning groups (CCG) to provide high-quality, cost-effective care nationwide.

Various approaches have been taken to address this problem, particularly restriction of access.¹ This has led to great variability in the criteria for referral, despite the NHS being a ‘national’ service. This has been highlighted in the treatment of carpal tunnel syndrome,² causing a form of ‘postcode lottery’. This may be appropriate for certain conditions; for example, there may be a particular emphasis on a specific condition associated with an ethnic minority in a part of the UK. For common conditions there should be broad agreement, as the population differences are unlikely to be such as to require substantially different criteria for treatment. The National Institute for Health and Care Excellence (NICE) was established in part to provide evidence-based guidance for clinicians. There may be reasons to deviate from this guidance, but these should be exceptional as the guidance is evidence based.

Hip osteoarthritis is estimated to affect 2.46 million of the population of the UK. Without surgical intervention, symptoms typically progress, with pain and limitation to the range of movement and restriction of mobility increasing over time. In 2016, 101,651 patients with hip osteoarthritis had surgery, typically total hip replacement.³ A meta-analysis of postoperative outcome measures has

shown overwhelmingly that patients who have undergone total hip replacement report an improvement in their quality of life.⁴ The aim of this study was to assess the referral criteria between different CCGs for consideration for total hip replacement.

Materials and methods

The policies for referral for consideration of primary hip replacement in each of the CCGs in England were obtained either using an online search (140 CCGs) or via Freedom of Information Act 2000 requests. Data were collected on the clinical criteria used for referral for specialist assessment and consideration of joint replacement surgery. The data were analysed for referral criteria including age, pain, subjective hip scores, prior treatment (i.e. physiotherapy and analgesia) and other criteria including weight (typically recorded as body mass index, BMI) and smoking status. Where we were not clear, we contacted the CCG again. We compared the policies with NICE guidance Osteoarthritis care and management:⁵

1.6 Referral for consideration of joint surgery

1.6.1 Clinicians with responsibility for referring a person with osteoarthritis for consideration of joint surgery should ensure that the person has been offered at least the core (non-surgical) treatment options (see recommendation 1.2.5) (2008).

1.6.2 Base decisions on referral thresholds on discussions between patient representatives, referring clinicians and surgeons, rather than using scoring tools for prioritisation (2008, amended 2014).

- 1.6.3 Consider referral for joint surgery for people with osteoarthritis who experience joint symptoms (pain, stiffness and reduced function) that have a substantial impact on their quality of life and are refractory to non-surgical treatment (2008, amended 2014).
- 1.6.4 Refer for consideration of joint surgery before there is prolonged and established functional limitation and severe pain (2008, amended 2014).
- 1.6.5 Patient-specific factors (including age, sex, smoking, obesity and comorbidities) should not be barriers to referral for joint surgery (2008, amended 2014).
- 1.6.6 When discussing the possibility of joint surgery, check that the person has been offered at least the core treatments for osteoarthritis (see recommendation 1.2.5), and give them information about: the benefits and risks of surgery and the potential consequences of not having surgery (recovery and rehabilitation after surgery; how having a prosthesis might affect them; how care pathways are organised in their local area) (new 2014).

Results

Of the 209 CCGs in England, 153 policies were available for review. Of these, 23 did not have a current regional policy available for review and 30 did not respond to FOI requests. All policies specified either directly or indirectly (e.g. via the Oxford Hip Score) that specific symptoms limiting patient's activities of daily life would prompt consideration for a total hip replacement. Sixty-three policies mandated that arthritis must be confirmed on radiographs. In accordance with the NICE guidelines, the majority of policies required a period of conservative treatment with simple analgesia prior to consideration for hip replacement. Fifty-four policies specified a duration of conservative management from two months (in one CCG) to six months (27 CCGs). Ninety-two policies stated that patients must undergo physiotherapy prior to consideration for surgical management.

Almost all policies (145) stated that measures such as weight loss should be pursued for those patients who were overweight, with ten specifying that patients with a BMI of greater than 25, 19 with a BMI greater than 30 and 38 with a BMI of greater than 35 or 40 would not be considered for surgery. Five policies specified that patients referred for surgery should have a 'healthy' BMI. Eleven CCGs made an exception to these rules if patients could demonstrate that serious attempts had been made to lose weight prior to referral. Six CCGs excluded patients from consideration for surgery if they were active cigarette smokers.

Forty policies made use of the Oxford Hip Score to stratify severity of patients' symptoms; in each of these policies, patients whose scores did not reach the threshold score were not eligible for referral for surgical intervention despite NICE guidance. The New Zealand and Salisbury hip scores were used in five CCGs to stratify severity of symptoms.

The data show that there is wide variation in the policies between CCGs regarding referral for hip replacement. Of

the policies reviewed, 41 were in compliance with NICE guidance and 40 showed some consideration of factors mentioned in the NICE guidance; the remaining 73 policies bore very little resemblance to the recommendations from NICE. There was no obvious evidence that specific local factors such as local ethnic groups or patient ages had informed the decision making.

Discussion

NICE guidelines state that primary total hip replacement is an option for treating end-stage arthritis of the hip that can be considered for those with osteoarthritis who experience symptoms (specifically pain, stiffness and reduced function) that have a substantial impact on their quality of life and are refractory to non-surgical treatment. They recommend that patients are offered non-surgical management initially. Exercise is the core intervention but NICE also suggests manipulation and stretching in the case of hip osteoarthritis. This is reflected in some of the CCG policies regarding referral for hip replacement; however, the recommendation that patients exercise is often conflated with the suggestion of losing weight to achieve a BMI of less than 25–30, which the NICE guidance suggests should not be a barrier to referral. NICE advises that patient factors such as smoking status and obesity should not preclude referral and that surgery should be considered before pain becomes 'severe' and there is a significant reduction in function. Arguably, this reduction in function means many patients with hip arthritis severe enough to warrant consideration for surgery find it difficult to exercise sufficiently to reduce their BMI.

NICE has specifically recommended against the use of scoring systems in referral management of hip osteoarthritis, yet 40 of the policies examined specify the use of the Oxford Hip Score as a tool to prioritise referral. All policies reviewed specified that pharmacological treatment be trialled by patients for variable amounts of time prior to referral for surgery; some apparently in isolation, while others suggested that other interventions such as physiotherapy and weight loss be pursued concurrently. NICE advocates intra-articular steroid injections prior to referral for surgery. Only five of the policies recommended this procedure. NICE does not recommend any particular period of time before referral. In contrast, almost all 153 CCG guidelines reviewed recommended a mean of three (range two to six) months of treatment prior to referral to surgery.

NICE guidance is guidance not mandated policy. Yet it is evidence based, drawn up by experts after a period of consultation. It is funded by government. It is therefore illogical for CCGs to ignore the guidance. This does not mean they have to follow it, but they should have clear reasons for rejecting it. Thus, while it may make sense for certain CCGs to extend certain criteria, such as the length of time non-operative treatment is undertaken or the time in a weight loss programme, it does not make sense to use criteria inappropriately, such as hip scoring systems, as hurdles for referral for which they were neither designed nor

validated. While it is unclear why CCGs would spend valuable resources devising their own criteria in the presence of NICE and other guidelines, such as the British Orthopaedic Association (BOA) NICE-approved guidelines,⁶ it is also unclear why other CCGs have no guidelines when they could simply refer to other established guidelines. In an NHS with limited resources, it seems entirely appropriate that there should be consistent criteria for patient referral and treatment.

There are limitations in this study. We did not achieve responses from all CCGs. The reasons behind some of the decision making of most the CCGs is unclear; a justification of their decisions may have made the data more understandable. Nonetheless the data represent a large number of CCGs across England.

Conclusion

CCG criteria for referral for total hip replacement are inconsistent across England, despite this being a very common, well-established procedure with considerable health

benefits. The inconsistency does not appear to be evidence based and will almost certainly disadvantage patients. In addition, it seems even more illogical in the presence of evidence-based guidelines available from NICE and the BOA.

References

1. Russell J, Greenhalgh T, Lewis H *et al*. Addressing the 'postcode lottery' in local resource allocation decisions a framework for clinical commissioning groups. *J R Soc Med* 2013; **106**: 120–123.
2. Ryan D, Shaw A, Graham S, Mason W. Variation in CCG policies for the treatment of carpal tunnel syndrome. *Bull R Coll Surg Engl* 2017; **99**(1): 28–31.
3. National Joint Registry. *14th Annual Report 2017: Surgical data to 31 December 2016*. Hemel Hempstead: NJR; 2017.
4. Shan L, Shan B, Graham D, Saxena A. Total hip replacement: a systematic review and meta-analysis on mid-term quality of life. *Osteoarthritis Cartilage* 2014; **22**: 389–406.
5. National Institute for Health and Care Excellence. *Osteoarthritis: Care and Management*. Clinical Guideline CG177. London: NICE; 2014.
6. British Orthopaedic Association, Royal College of Surgeons of England. *Commissioning Guide: Pain Arising from the Hip in Adults*. London: RCS; 2017.