# Policy Position Paper

## ‘Rationing’
## Access to Joint Replacement Surgery and Impact on People with Arthritis and Musculoskeletal Conditions

August 2017

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ARMA is the umbrella organisation for the UK musculoskeletal community. Our member organisations are:

Acupuncture Association of Chartered Physiotherapists (AACP)
Arthritis Action
Arthritis Care
Arthritis Research UK (AR UK)
BackCare
British Acupuncture Council (BAC)
British Association of Sport & Exercise Medicine (BASEM)
British Chiropractic Association (BCA)
British Medical Acupuncture Society (BMAS)
British Orthopaedic Association (BOA)
British Society for Rheumatology (BSR)
British Society of Rehabilitation Medicine (BSRM)
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The Society of Musculoskeletal Medicine (SOMM)
UK Gout Society



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## 'Rationing'
## Access to Joint Replacement Surgery and Impact on People with Arthritis and Musculoskeletal Conditions

### Overview:

**The Arthritis and Musculoskeletal Alliance (ARMA) is extremely concerned about increasing restrictions to access NHS services for joint replacements and the impact on people with musculoskeletal conditions.**

In the past year there has been a noticeable increase in reports of restrictions to eligibility/referral criteria for joint replacements by a growing number of NHS services. The NHS is currently operating under severe financial pressure and looking at ways to manage demand for high volume procedures such as hip and knee replacements. Financial pressures have led to nearly half of CCGs (47%) imposing restrictions on overweight or obese patients being referred for elective surgery.[1] Patients are required to stop smoking in 12% of CCGs before they can access one or more routine surgical procedures.[2] In other cases, eligibility/referral criteria are based on scoring tools, with arbitrary thresholds set that are not designed for this purpose.

The NHS England document Next steps on the *Five Year Forward View*[3] published in March 2017 discusses the referral to treatment time (RTT) 18-week 92% target for elective surgery, saying: *"…elective [surgery] volumes are likely to expand at a slower rate than implied by a 92% RTT incomplete pathway target."* This implies a slow down on the RTT performance against the 92% target; thus, waiting times for joint replacement surgery are expected to lengthen.

These developments have a significant impact on people with arthritis and musculoskeletal conditions because osteoarthritis is responsible for over 90% of hip and knee replacements.[4] There is evidence that increasing the waiting time for hip replacement surgery in people with severe pain and reduced mobility results in less good outcomes. Increasing waiting times may worsen pain, suffering and mobility, both during the time spent waiting for surgery and (in some cases) permanently, and is not cost effective in the long-term.[5] Furthermore, data from national audits of the outcomes from these procedures indicates that the health quality of life gain remains high in those CCGs that have higher operation rates.

## Key messages on rationing of access to joint replacement surgery

- Increasing numbers of people are requiring joint replacement surgery[6] but there has been notable media coverage focusing on clinical commissioning groups (CCGs) restricting access to elective treatments, including joint replacement.[7]

- 47% of CCGs restrict access to joint replacements based on being overweight or obese[8] with some CCGs putting Body Mass Index (BMI) thresholds as low as 25 or 30, restricting a considerable proportion of the population from the option of surgery.

- In some CCGs, restrictions on surgery have been based on scoring tools, such as the Oxford Hip and Knee Scores, despite the fact that there is no supporting clinical evidence for their use in this way.

- Arbitrary thresholds based on BMI, smoking and scoring tools are not appropriate, and surgery should be based on clinical need.

- At the end of 2015/16 trauma and orthopaedics was one of ten specialities that fell below the incomplete waiting time standard of 92% .[9]

- Given that in 2015 there were 89,288 primary hip replacement procedures (of which 90% were due to osteoarthritis) and 98,591 primary knee replacement procedures (of which 98% were due to osteoarthritis), we are concerned about the significant impact restricting access could have on people with arthritis[10].

- For people with severe osteoarthritis, joint replacement surgery is usually very effective at reducing pain and restoring independence. Delays to treatment can lead to worse outcomes for patients.[11]

- Hip and knee replacements are cost-effective procedures.[12]

## Key outcomes we are seeking

- Guidance from the British Orthopaedic Association (BOA) makes it clear that referral for joint replacement surgery should be based on clinical need, following discussion between the patient, referring clinicians and surgeons. Scoring tools and thresholds for prioritisation should not be used.[13]

- Services should be built around the needs of the individual, who must have the ability to choose and control the type of support provided using a Shared Decision-Making approach.[14]

- National Institute for Health and Care Excellence (NICE) clinical guidelines should be followed so that 'patient-specific factors' (including age, sex, smoking, obesity and comorbidities) should not be barriers to referral for joint surgery'. [15]

- Under the NHS constitution everyone has the right to access NHS services. No one should be refused access on unreasonable grounds. [16]

- Once surgery is agreed as the best option for treatment, surgery should be provided at an appropriate time, based on the clinical need of the patient. Some patients may need treatment in less than 18 weeks.

- Irrespective of financial constraints, clinical commissioning groups are expected to meet patients' legal rights under the NHS Constitution and best practice guidance as set out by NICE and the BOA.

- NHS England, NHS Improvement and Clinical Commissioning Groups should ensure that patients' rights to access treatment, as set out in the NHS Constitution, are met.

## Thresholds and scoring tools

Against a backdrop of an NHS deficit of £2.45 billion in 2015/16, and despite increasing numbers of people requiring joint replacement surgery[17], clinical commissioning groups (CCGs) are restricting access to elective treatments, including joint replacement.[18]

Patients are increasingly struggling to get access to treatment. Between 2012 and 2014, the number of people with osteoarthritis who reported having had a joint replacement fell from 25% to 20 %.[19] This decline is not the result of increases in alternative support; in fact, fewer people reported use of other treatments and therapies. This suggests that people with osteoarthritis found it more difficult to access the help they need from health services in 2014 than in 2012.

Pain is one of the most common symptoms of musculoskeletal conditions and a delay in surgery may result in patients living with daily pain[20] , plus barriers to mobility and independence, compromising their wellbeing and quality of life. For people with severe osteoarthritis, joint replacement surgery is usually very effective at reducing pain and restoring independence. Delays to treatment can lead to worse outcomes for patients.[21]

We have concerns about two types of restrictions being introduced by CCGs: those regarding BMI and smoking, and others based on using scoring tools.

### *BMI and smoking status*

In some cases, new referral criteria for elective surgery have been introduced or proposed that are based on patient factors such as BMI or smoking status, rather than the needs of patients. From 2014 to 2016 the number of CCGs that have a BMI threshold for accessing joint replacement surgery has more than trebled. BMI is used as a way of seeing if body weight is appropriate for height and assessing the weight-related health risk. In general, the higher the BMI, the more body fat the person has. BMI can be divided into several categories, with BMI of 18.5 to 24.9 considered the ideal weight range, BMI of 25 to 29.9 as overweight and BMI of 30 or more as obese.

A report by the ABHI[22] shows that of the 141 CCGs out of 209 who have published guidelines on hip and knee replacements, 69% have a BMI threshold. Eight have a BMI threshold of only 25 and thus, a woman who

is 5ft. 4in. tall, weighing 10st 7lbs or more, or a man 5ft 10intall weighing 12st 9lbs or more would not be eligible for surgery. Out of the 141 CCGs, 20 had a BMI threshold of 30, so a woman who is 5ft 4 in tall who was 12st 8lbs or a man who was 5ft 10in tall weighing 14st 14lbs or more would not be eligible for surgery. The BMI thresholds that are being set are not particularly high BMI levels and are therefore very restrictive, ruling out a significant proportion of the population from accessing surgery.

Rationing surgery by applying thresholds for weight and smoking is likely to disproportionally affect those on low incomes who are more likely to be obese and smoke and suffer worse health, which may deepen health inequalities. Using such thresholds is entirely contrary to the NICE clinical guidelines that state 'patient-specific factors (including age, sex, smoking, obesity and comorbidities) should not be barriers to referral for joint surgery'.[23] Under the NHS constitution everyone has the right to access NHS services. No one should be refused access on unreasonable grounds.[24] Irrespective of financial constraints, clinical commissioning groups are expected to meet patients' legal rights under the NHS Constitution and best practice guidance as set out by NICE and the BOA. In addition, GMC guidance advises that doctors 'must not refuse or delay treatment because you believe that a patient's actions or lifestyle have contributed to their condition.'[25]

***Scoring tools***

Some CCGs have used surgery thresholds based on scoring tools, such as the Oxford Hip Score, with patients denied surgery unless they reach a certain score for their pain, joint function and level of disability.[26] These scoring tools were not designed for this purpose, there is no clinical justification for application of them in this way, and this results in arbitrary thresholds for surgery.

NICE guidance indicates this is not acceptable; it requires that referral decisions are based 'on discussions between patient representatives, referring clinicians and surgeons, rather than using scoring tools for prioritization'.[27] Guidance from the BOA also makes it clear that referral for joint replacement surgery should be based on clinical need, following discussion between the patient, referring clinicians and surgeons. Scoring tools and thresholds for prioritisation should not be used.[28]

## Waiting times

Patients have the right to start consultant-led non-emergency treatment within a maximum of 18 weeks of a GP referral and the NHS must take reasonable steps to arrange a range of alternatives if this is not possible.[29] However, with increasing financial strain on the NHS, and as detailed in the *Next Steps for the Five Year Forward View*, there will be a slow down in the 18-week waiting time referral to treatment target for 'non-urgent' surgery, such as hip and knee replacement surgery. Waiting times for surgery are increasing[30] and are likely to continue to do so.

In 2015, 89,288 people had a primary hip replacement and 98,591 people had a primary knee replacement in England and Wales[31], with osteoarthritis as the main cause.[32] As both age and obesity are risk factors for the development of osteoarthritis, the number of people with knee osteoarthritis is estimated to increase from 4.7 million in 2010 to 8.3 million in 2035.[33]

Most patients will not need surgery, with their symptoms adequately controlled by non-surgical measures. Expanding the primary care team, for example using allied health professions, is shown to reduce the number of inappropriate orthopaedic referrals to secondary care. This reduces costs and cuts waiting times, ensuring surgeons' time is spent well and patients get faster access to the care they need.

For people with severe osteoarthritis, joint replacement surgery is usually very effective at reducing pain and restoring independence. Delays to treatment can lead to worse outcomes for patients.[34] Symptoms worsen in 15% of patients within three years and 28% within six years.[35]

For any surgery, it is important that patients can access the intervention at an appropriate time. The delays in treatment mean that people with severe arthritis are living in pain for longer.[36] Delays to surgery can have multiple consequences for the patient: it can mean they don't have such a good outcome from the surgery, as well the extended wait resulting in muscle wasting due to immobility, reduced cardiovascular fitness, osteoporosis due to immobility and adverse effects on the patient's mental health and motivation caused by chronic pain; the delay may result in permanent impaired mobility in some cases. In certain patient groups, especially those with rapidly progressive hip osteoarthritis, a delay in surgery can result in the need for more complex surgery (at increased cost)

with greater risks of complications, as well as poorer outcomes.

People are often living with pain for years before they approach their GP.[37] The last weeks from referral to treatment are merely, as patients put it themselves, 'the tip of the iceberg'. There may be instances where people are comfortable waiting for longer or it is clinically appropriate for someone to wait longer. However, the presence of pain means the treatment delays can have an impact across an individual's entire life[38] – their ability to work, family commitments and mental health.

Focusing on yearly NHS budget challenges is counter-intuitive and risks missing the real essence of the task facing the NHS, which is about getting better value from the NHS budget. This means maximising the outcomes produced by the activities the NHS carries out, while minimising their costs. One way to maximise outcomes is by making use of the whole of the musculoskeletal pathway, particularly early intervention and prevention. Once surgery is agreed as the best treatment option, then the wait for surgery should be the shortest possible.[39] The delays can have other costs to the NHS and to the patient: the long-term use of analgesic, opioids or NSAIDs (non-steroidal anti-inflammatory drugs) can have significant side-effects, with long term opioid addiction being a real risk; and ultimately continuing use of other therapies in the presence of significant disease is a further waste of NHS resources.

## The role of surgery

Surgery can be an excellent option to alleviate the pain and disability of many musculoskeletal symptoms. Procedures such as joint replacement surgery result in significant benefit to the patient in terms of pain relief, improvement in function, quality of life and restoring independence. This is evident in National Joint Registry statistics[40] showing proven sustainable benefit with low complication rates when the surgery uses well proven prostheses.

The literature would support the notion of an increased complication rate in the morbidly obese (>40) and heavy smokers[41] but the principle that must be maintained is that ultimately the decision to proceed with surgery must be a joint decision between the patient and the specialist surgeon, taking into account an individual's circumstances and risk profile. There is also evidence that overweight or obese patients who lose weight prior to surgery may not have lower complication rates, potentially because the weight loss can adversely affect the immune system over an extended period.[42]

## Healthy behaviours and preparation for surgery

From the moment the patient and surgeon decide that a total joint replacement is an appropriate treatment, they should make every effort to make best use of the time available prior to the procedure being carried out. This will involve making the necessary preparations for the post-operative period which may include home support, modifications, family arrangements etc. Modifications to lifestyle that may contribute to an improved outcome, smoother recovery and better general health, should also be discussed and supported. It is recognised the lifestyle modifications to achieve weight loss or stopping smoking are difficult to achieve and this should not be a bar to joint replacement if the patient and surgeon agree that the best option is to proceed.
We support the principle of commissioners providing effective weight loss management programmes where appropriate.

ARMA also supports the use of prevention strategies including promoting healthy lifestyles across the population so that more people avoid needing hip or knee replacement in the longer term.

## Guidance and further information

- Arthritis Care Consultation Response, Work, Health and Disability Green Paper, February 2017
- Arthritis Research UK, *Briefing Pack on 'rationing' and patient rights in the NHS June 2017*.
- *British Orthopaedic Association Commissioning Guidelines: Pain Arising from the Hip in Adults; Painful Osteoarthritis of the knee.*
- *NHS Constitution*
- *NHS Mandate 2016-17*
- NICE Clinical Guideline [CG177] Osteoarthritis: care and management (February 2014)
- NICE Quality Standard [QS87]: Osteoarthritis (June 2015)

# References


1 ABHI (2017). *Hip and Knee Replacement: The Hidden Barriers*

2 The Royal College of Surgeons (2016). *Smokers and overweight patients: Soft targets for NHS savings?* p11

3 *Five Year Forward View*

4 National Joint Registry (2016). *NJR Annual report*

5 Rigge B. et al (2002). *Journal of Health Services Research and Policy*, Vol. 7, p 19-25

6 National Joint Registry (2016). *13th Annual Report National Joint Registry for England, Wales, Northern Ireland and the Isle of Man, Surgical data to 31 December 2015*

7 Arthritis Research UK (June 2017). Briefing on 'rationing' and patient rights in the NHS.

8 ABHI (2017). *Hip and Knee Replacement: The Hidden Barriers*

9 NHS England (2016). Referral to treatment (RTT) waiting times statistics for consultant-led elective care, 2015/16 Annual Report

10 National Joint Registry (2016). *NJR Annual report*

11 Rigge B. et al (2002). *Journal of Health Services Research and Policy*, Vol. 7, p 19-25

12 Jenkins P et al (2013). Predicting the cost-effectiveness of total hip and knee replacement: a health economic analysis. *Bone and Joint Journal* Jan, 95-B (1):115-21.

13 British Orthopaedic Association (2016). *Commissioning guide: painful osteoarthritis of the knee*

14 Shared Decision Making (SDM) is a collaborative process through which a clinician supports a patient to reach a decision about their treatment. The conversation brings together the clinician's expertise, such as treatment options, evidence, risks and benefits, and what the patient knows best: their preferences, personal circumstances, goals, values and beliefs.

15 National Institute for Health and Care Excellence (February 2014). Osteoarthritis: care and management. Clinical guideline CG177

16 Department of Health (2015). *The NHS Constitution for England*.

17 National Joint Registry (2016). *13th Annual Report National Joint Registry for England, Wales, Northern Ireland and the Isle of Man, Surgical data to 31 December 2015*

18 Arthritis Research UK (June 2017). *Briefing on 'rationing' and patient rights in the NHS.*

19 Arthritis Care, 2014, *Arthritis Nation*, based on two YouGov surveys of over 2000 people with arthritis.

20 *Policy spotlight, Arthritis, joint replacements and patients' rights under the NHS Constitution,* Arthritis Research UK

21 Rigge B. et al (2002). *Journal of Health Services Research and Policy*, Vol. 7, p 19-25

22 ABHI (2017). *Hip and Knee Replacement: The Hidden Barriers*

23 National Institute for Health and Care Excellence (February 2014). Osteoarthritis: care and management. Clinical guideline CG177

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[24] Department of Health (2015). *The NHS Constitution for England*.

[25] GMC Guidance

[26] RCS responds to CCGs' plans to ration hip and knee surgery using Oxford score, January 2017

[27] NICE (2014), Osteoarthritis: care and management, para 1.6.2

[28] British Orthopaedic Association (2016). *Commissioning guide: painful osteoarthritis of the knee*

[29] Department of Health (2012). Statutory Instruments 2012 No.2996. The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012. *(The legislation that establishes this right is the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012*).

[30] https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/increase-in-number-of-patients-waiting-for-planned/

[31] National Joint Registry (2016). *NJR Annual report*

[32] National Joint Registry (2016). *13th Annual Report National Joint Registry for England, Wales, Northern Ireland and the Isle of Man, Surgical data to 31 December 2015*

[33] Arthritis Research UK (2013). Osteoarthritis in General Practice: data and perspectives.

[34] Rigge B. et al (2002). *Journal of Health Services Research and Policy*, Vol. 7, p 19-25

[35] Prognosis of hip pain in general practice: a prospective followup study. Lievense AM, Koes BW, Verhaar JAN, Bohnen AM, Bierma-Zeinstra S. 8 , 2007, Arthritis Care and Research, Vol. 57, pp. 1368-74.

[36] Policy spotlight, Arthritis, joint replacements and patients' rights under the NHS Constitution, Arthritis Research UK, p5.

[37] https://www.arthritiscare.org.uk/about-us/news/1032-people-enduring-years-of-pain-before-seeking-help-for-arthritis

[38] *Policy spotlight, Arthritis, joint replacements and patients' rights under the NHS Constitution*, Arthritis Research UK, p9.

[39] Does waiting for total hip replacement matter? Prospective cohort study. Hajat S, Fitzpatrick R, Morris R, Reeves B, Rigge M, Williams O, Murray D, Gregg P. 1, 2002, J*ournal of Health Services Research and Policy*, Vol. 7, pp. 19-25.

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[41] Martin JR, Jennings JM & Dennis DA (2017) Morbid obesity and total knee arthroplasty: A growing problem *J Am Acad Orthop Surg* 25:188-194; Duchman KR *et al*. (2015) The effect of smoking on short-term complications following total hip and knee arthroplasty *J Bone Joint Surg Am* 97:1049-58; Tischler EH et al. (2017) Smoking increases the rate of reoperation for infection within 90 dats after primary total joint arthroplasty *J Bone Joint Surg Am* **99**: 295-304.

[42] Martin JR, Jennings JM & Dennis DA (2017) Morbid obesity and total knee arthroplasty: A growing problem *J Am Acad Orthop Surg* 25:188-194.


Arthritis and Musculoskeletal Alliance
Bride House
18-20 Bride Lane
London
EC4Y 8EE

Tel: +44 (0) 203 856 1978
projects@arma.uk.net
www.arma.uk.net
@WeAreArma

Registered Charity No: 1108851
Registered Company No: 5380237