



## Appendix 3c, 4c & 5c

### Hip & Knee Arthroplasty and Knee Arthroscopy Task and Finish Group meeting, 9 May 2018

#### Notes of key discussion points

#### Task and Finish Group members

Attendees:		
Sam Oussedik	Consultant Trauma and Orthopaedic Surgeon	NCL
Adil Ajuied	Consultant Knee Surgeon / Senior Hon. Clinical Lecturer	SEL
Ethan Harris-Faulkner	GP Bexley	SEL
Maurice Sanomi	GP, Clinical Director Havering CCG	NEL
Imran Sajid (Chair)	GP and Chair, NWL Policy Development Group Governing Body Executive, West London CCG; Clinical Lead, WLCCG Musculoskeletal, Diagnostics & Urgent Care	NWL
Jane Hopkins	Lay representative; lay advisor Greenwich CCG	SEL
Rosie Andrews	Nurse / Public Health, Public Governor for Kings Health Care	
Apologies		
Folake Segun	Chief Executive Healthwatch (Bromley and Lewisham) and Community Waves	SEL

#### Also in attendance:

Pida Ripley	Patient Representative	London Choosing Wisely Steering Group
Jane Halpin	Director	Deloitte
Nikita Patel	Senior Consultant	Deloitte
Catharine Geldart	Senior Consultant	Deloitte
Danny Batten	Acting Director of Transformation and Delivery (NEL)	NHSE
Mandip Korotana	Programme Manager	Healthy London Partnership
Kunle Awosanya	Project Manager	Healthy London Partnership

#### 1. Welcome from Imran Sajid, Chair of the Task and Finish Group

The Chair welcomed members and outlined the purpose of the meeting. The Chair confirmed that:

- the meeting was quorate

- there were no conflicts of interest
- the meeting will focus on hip and knee arthroplasty

## 2. Presentation of the evidence review from Jane Halpin, Nikita Patel and Catharine Geldart

Colleagues from Deloitte presented the draft evidence reviews which had been circulated in advance to Task and Finish Group members. They pointed out that NICE guideline – Osteoarthritis: care and management are the same for hip and knee arthroplasty. Both reviews have also used guidance from the Royal College of Surgeons (RCS) and the British Orthopaedic Association (BOA) commissioning guide, as well as a review of CCG policies across London.

### Hip athroplasty

It was noted that NICE osteoarthritis (OA) and RCS/BOA guidelines are broadly in agreement in terms of referral for total hip replacement for patients with hip osteoarthritis. Both refer to a period of conservative treatment prior to referral to secondary care for surgical treatment. However, there are subtle differences in the wording, for example, NICE says “significantly impacts quality of life” whereas RCS/BOA says “quality of life is significantly compromised”, with neither offering a qualifying or defining statement for the terms used. Therefore, both sets of guidance are open to a degree of individual interpretation.

This variation has been reflected in the wording of total hip replacement policies across London. BHR, SWL, NWL have policies in place for THR. There were five key areas whereby there was deviation from the guidelines or variation across the policies:

1. Wording and definitions of severity of pain and function
2. Duration of the conservative treatment
3. Whether weight reduction is required to optimise outcomes of surgery
4. Whether radiological findings should be included
5. Whether specific scores for the hip should be done

The evidence relating to the specific time period for conservative treatment for hip osteoarthritis prior to hip replacement is inconclusive. There is a lack of high quality randomised controlled trials assessing the optimal duration of conservative treatment.

### Knee arthroplasty

It was noted that there were similar issues on areas that are open to interpretation with knee arthroplasty guidance and policies across London. Total knee replacement (TKR) is known to be a clinically and cost effective treatment for knee osteoarthritis in patients with persistent and troublesome symptoms that are refractory to conservative management. However, the NICE guideline does not specifically state when patients should be referred for consideration of joint surgery. Symptoms of knee OA can be classified in various ways and there are several pain and function scoring systems (patient-reported outcome measures) that are in clinical use. However, none have been validation as thresholds for surgery. There are no high quality trials that have assessed the optimum timing of joint replacement surgery.

## 3. Discussion on the evidence: is it robust and of high quality?

The key discussion points were as follows:

- It was clear that the policy did not cover children and malignancy
- It was unclear where young people fit within this policy. Following discussion, it was agreed that it should be explicit that this policy is restricted to elderly people with osteoarthritis. However, an age for the “elderly” was not defined. Instead, young people with hip disease were to be excluded from the policy.
- Those with haemophilia or sickle cell disease should be excluded from the policy.
- It was noted that hip resurfacing is excluded in the policy, primarily because current CCG policies in London do not include this. It was discussed whether this might be opportunity to include this and tidy up anomalies. Given that the surgeon will make the decision on the appropriate hip procedure, it was agreed that procedure exclusions do not sit well in the policy.
- The Group discussed whether the policy could be used to encourage best practice guidance i.e. to exhaust conservative management first. Group members felt that this was very important, particularly at primary care level, to avoid unnecessary surgery.
- Whilst this was the case, it was also noted that unnecessary waiting times causing delays to surgery can lead to poorer clinical outcomes for the patient that does need treatment.
- The use of scores in referral thresholds was discussed and it was felt that scoring systems had not been validated, therefore should not be included in a pan London policy. NICE guidelines also do not prescribe the use of scoring systems as a referral criterion.
- It was noted that the mortality rate after knee surgery was stated as up to 1% in the evidence review, but it is believed to be 0.53%.

It was agreed that the Group were satisfied with the evidence presented, subject to correction of the mortality rate for knee arthroplasty.

#### 4. Drafting the London policy

##### Hip arthroplasty

The following were discussed and agreed for hip arthroplasty:

- There should not be a fixed timeline on duration for conservative management:
  - It is not just necessarily about length of treatment but also levels of patient engagement in the treatment
  - Accessibility and quality of physiotherapy varies across London making it difficult to standardise and include a specific duration of treatment in the final policy
  - Patients may delay seeking help until the condition is very bad, making it difficult to engage in physio
  - For some patients, physio will have no impact on the condition i.e. those with fixed rotation or those with end stage OA, although a definition of “end stage OA” is open to a degree of interpretation.
- The wording on conservative management in the draft policy needs to manage different issues – easy access to treatment for patients with end stage OA hip disease whilst pursuing conservative treatment for those who are not engaging sufficiently well in this.

- A shared decision making approach, as suggested in NICE guidelines and adopted in SWL should be incorporated into the London policy. Shared decision making aid examples were shared, including those on the HealthWise Cochrane websites.
- It was agreed that there should not be a classification system for severity of pain or functional impairment as there was no standard definition in any guidance and these are subjective. Clinical judgement should be used.
- The option of having a series of prompt questions to explore pain and function was considered. It could be helpful but there is a risk that it could limit broader thinking and become a tick box exercise. This will be re-visited as part of the review of the draft policy.
- It was agreed that whilst smoking cessation should be offered to patients, this should not be a barrier to surgery, in line with NICE guidelines and the RCS/BOA guide. It was noted that patients who stop smoking <4 weeks before surgery have worse outcomes. However, there is evidence that smoking cessation improves wound healing, post-op recovery time, infection rate etc. and therefore, it should be encouraged, at least 12 weeks before surgery.
- The Group agreed that there should be no BMI cut off in the London policy as no specific BMI was referred to in the guidance reviewed, but weight reduction support should be offered, with access to weight loss services where they are available. It was noted that this was particularly relevant for knee arthroplasty.
- The criteria should make it clear that, only patients willing to consider surgery should be referred to secondary care.
- It was noted that there are different patient pathways across London, with most GPs referring via interface services. It was agreed that the policy also applied to these services, and needed to specify that it was for both primary and secondary care.
- It was agreed that all patients undergoing hip arthroplasty should have had plain radiographs prior to the procedure.

### Knee arthroplasty

The following were discussed and agreed for knee arthroplasty:

- It was agreed that as with hip arthroplasty, that there would be no specific time period for conservative treatment, however patients should exhaust conservative options before undergoing TKR.
- As with THR, there should be no classification system for severity of pain or functional pain.
- It was agreed that as with hip arthroplasty, smoking cessation and weight reduction support should be offered. It was noted that weight reduction was particularly important for knee arthroplasty.
- It was agreed that shared decision making should also be included in the policy, as with hip arthroplasty, to guide conversations on quality of life, including reputable tools / aides as examples.
- Partial knee replacement should be included in the policy, given that it was the same cohort of patients, the same criteria and the same pathway. However, this should be checked as part of the guidance review in both the NICE guidelines and RCS/BOA commissioning guide. It was noted that given the technology, the use of this procedure is likely to increase.

- It was agreed that radiological diagnosis of degenerative disease should be included in the clinical criteria for referral.

## **5. Review of the draft policy (statements above) against the ethical application sheet**

The statements and process were reviewed against the key principles and considerations of the ethical framework. The group agreed that decisions were:

- Rational: It was noted that the evidence on partial knee replacement needed to be reviewed
- Socially inclusive:
  - It was important the information for patients should be accessible, and written in community languages
  - Shared decision making aides should also be accessible
  - It was noted that each CCG will also be carrying out an equalities impact assessment
  - Impact of delayed treatment was discussed, not only on clinical outcomes but on quality of life such as loss of independence. It was agreed that the removal of time-limits on conservative management should help address inappropriate delays.
- Clear and open to scrutiny
- Economic factors had been taken into account
- Promoted health

## **6. Next steps**

It was agreed that Deloitte will draft the London policy, harmonising the NEL, SWL and NWL CCG criteria where appropriate, in line with the decisions above.

The policy will be reviewed and approved at the next meeting on 16 May.

## Hip & Knee Arthroplasty and Knee Arthroscopy Task and Finish Group meeting, 16 May 2018

### Notes of key discussion points

#### Task and Finish Group members

Attendees:		
Fares Haddad	Hip and Knee Reconstructive Surgeon	NCL
Adil Ajuied	Consultant Knee Surgeon / Senior Hon. Clinical Lecturer	SEL
Ethan Harris-Faulkner	GP Bexley	SEL
Maurice Sanomi	GP, Clinical Director Havering CCG	NEL
Imran Sajid (Chair)	GP and Chair, NWL Policy Development Group Governing Body Executive, West London CCG;	NWL
Jane Hopkins	Lay representative; lay advisor London Borough of Greenwich, Adultcare Transformation Group and Healthwatch Greenwich	SEL
Rosie Andrews	Nurse / Public Health, Public Governor for Kings Health Care	
Apologies		
Folake Segun	Chief Executive Healthwatch (Bromley and Lewisham) and Community Waves	SEL

#### Also in attendance:

Pida Ripley	Patient Representative, British Orthopaedic Association Patient Liaison Group (BOA PLG)	London Choosing Wisely Steering Group
Jane Halpin	Director	Deloitte
Catharine Geldart	Senior Consultant	Deloitte
Danny Batten	Acting Director of Transformation and Delivery (NEL)	NHSE
Mandip Korotana	Programme Manager	Healthy London Partnership
Kunle Awosanya	Project Manager	Healthy London Partnership

#### 7. Welcome from Imran Sajid, Chair of the Task and Finish Group

The Chair welcomed members and outlined the purpose of the meeting. The Chair confirmed that:

- the meeting was quorate
- there were no conflicts of interest

#### 8. Agreement and sign off on notes of previous meeting

The group reviewed the notes from the previous task and finish group meeting and the following comments were made:

- The statements ‘*Duration of the conservative treatment*’ (pg 2) and ‘*Group members felt that this was very important, particularly at primary care level, to avoid unnecessary surgery*’ (pg 3) need to indicate poor clinical outcome resulting from waiting and delays. It was agreed to reword the statements to balance conservative management against timely access.
- The statement ‘*Total knee replacement (TKR) is known to be an effective treatment for knee osteoarthritis*’ (pg 2) should include cost effectiveness.
- The statement ‘*each STP will also be carrying out an equalities impact assessment*’ (pg 5) , should be corrected to say ‘*each CCG*’.

Subject to these amendments being made, the Group agreed that the notes were a true and accurate record of the previous meeting.

## **9. Review and agreement on draft policies for hip arthroplasty and knee arthroplasty**

There was a discussion about the varying quality and access of interface services across London, and the cuts to local authority services such as weight loss support. The Group agreed that this was an issue, but was outside the scope of the Task and Finish Group. It was noted that this was a theme emerging across a number of Task and Finish Groups, so should be flagged to the London Choosing Wisely Steering Group, and to CCGs. However, it was noted that the London policy had removed some barriers, such as BMI, in terms of access to treatment.

The Group approved policies for:

- Hip arthroplasty
- Knee arthroplasty – subject to the amendment suggested by Adil that “General Anaesthesia” is replaced with “Anaesthesia” and Jane’s comments on that the policy should state that knee arthroplasty has been shown to be clinically and cost effective.

These policies will now move to the two week testing phase where the policies are sent to wider stakeholders via an online survey for feedback on language, usability and presentation. The online survey will also be sent to Task and Finish Group members for their comment, and for them to engage key colleagues.

The final policies, subject to any final amendments on language and presentation approved by the Chair of the Task and Finish Group, will be presented at the London Choosing Wisely Steering Group on 3 July.

## **10. Presentation of the evidence review for knee arthroscopy: Catharine Geldart and Jane Halpin**

Colleagues from Deloitte presented the draft evidence review which had been circulated in advance to Task and Finish Group members. The following points were highlighted:

- Given that NICE guidance is quite clear that arthroscopic lavage and debridement has no benefit in the treatment knee osteoarthritis, there was a change of scope to include knee arthroscopy for partial meniscectomy.

- The NICE guidance published in 2008 coincided with the publication of a Cochrane review which concluded that there is “gold” level evidence that arthroscopic debridement has no benefit for the treatment of undiscriminated osteoarthritis.
- In 2013, the British Orthopaedic Association (BOA) produced a commissioning guidance document “Painful osteoarthritis of the knee” which reiterates the NICE guidelines that the specific case of mechanical locking is the only indication for therapeutic arthroscopy in patients with degenerative disease. They also added that it may be used for diagnostic purposes prior to other surgical interventions.
- Every CCG in London has a policy in place for knee arthroscopy. All of them, as a minimum, refer to lavage and debridement as not routinely funded. South West London and North West London specifically have more general arthroscopy policies in place which details which specific knee arthroscopic interventions will and will not routinely be funded.
- In terms of partial meniscectomy, arthroscopic partial meniscectomy is performed in middle or older aged patients with meniscal tear. The origin of this tear is not necessarily clear.
- Systematic reviews comparing effectiveness of arthroscopic interventions have limitations, often due to heterogeneity between studies in terms of inclusion/exclusion criteria.
- Partial meniscectomy offers at best a small benefit in the short term in terms of pain and function improvement over conservative management in patients with degenerative meniscal tears with or without osteoarthritis. However, in some of these trials, the benefits sustained did not meet the threshold that would be deemed of clinical importance or significance to patients.
- In most of the evidence reviewed, there was no significant benefit for the patients in the longer term 1-2 years later over those who have had conservative management.

#### **11. Discussion on the evidence: is it robust and of high quality?**

The key discussion points on knee arthroscopy were as follows:

- It was clear that there is no place for knee arthroscopy for painful osteoarthritis.
- However, patients may have mechanical pathology that further exacerbate their symptoms and debilitates their function.
- Medium meniscal tears in an arthritic knee can be debilitating.
- For bone on bone, the role of arthroscopy is very limited.
- NICE guidelines have clear statement about mechanical locking.

In terms of partial meniscectomy, the key discussions were as follows:

- It should be noted that studies often have a cohort of patients that are self-selected, and have access to a physiotherapy programme that is very structured and many other patients won’t have. There is also a high level of cross over from the non-operative to the operative arm.
- The impact of three to six months of severe pain on a working person’s life should not be underestimated.
- However it was agreed that there is over operation for meniscal tears.
- A scan of people over the age of forty would show that 40% will have a meniscal tear and be asymptomatic. A tear does not necessarily mean operation; it has to be symptomatic and have failed conservative treatment before advocating surgical intervention.

- The group agreed that are often being patients are being propelled into secondary care, particularly with the increase of diagnostics in primary care.
- The GP faces a difficulty when “orthopaedic referral is advised” is written on the report in terms of patients expectations.
- Whilst the UK is ahead of the curve and operations for meniscal tears have declined, there is a need to tighten up the policy, whilst balancing the need for clinical judgement.

It was agreed that the evidence was sufficiently robust to enable the Group to proceed to drafting a London policy.

## 12. Drafting the London policy

The key discussion points were as follows:

- The pan London policy should re-iterate NICE guidance that knee arthroscopy in the treatment knee osteoarthritis will not be routinely funded apart for cases of mechanical locking.
- The Group discussed the draft British Association for Surgery of the Knee (BASK) / British Orthopaedic Association (BOA) Treatment Guidance on the best practice for arthroscopic meniscal surgery which had been circulated to members ahead of the meeting. This includes a flow chart of integrated assessment, common clinical presentations and recommendation for treatment. This guidance has been devised by consensus of 25-30 senior knee surgeons across the UK, who met on four occasions, reviewed the evidence and went through a number of iterations and case scenarios to try and develop answers to the difficult questions within the scenarios.
- The group agreed that the BASK / BOA flow diagram was a useful basis for the London policy, but it needed to be converted into a set of clinical criteria statements.
- It was agreed that acute locked knee, as per the BASK diagram, should be referred for urgent meniscal surgery. However ‘acute locked knee’ needs to be defined in the policy.
- For 2. Advanced Structural OA, it was agreed that patients with advanced structural OA (equivalent to Kellgren-Lawrence Grade III and above) would not usually be appropriate for arthroscopic meniscal surgery.
- It was noted that the key issue was between categories 3. Acute injury with meniscal target (MRI) and 4. Meniscal Target (MRI) & corresponding symptoms / signs. Category 3 had been created to take a group of patients from category 4, who could be treated, and should not have to wait. This patient group has a non-arthritic knee injury, most often traumatic rather than degenerative.
- For category 4. Meniscal Target (MRI) & corresponding symptoms / signs, a majority of patients will improve with conservative treatment and should not have surgery.
- There was a discussion about category 4 patients that don’t improve with conservative treatment and how they are identified. There was a discussion about mechanical symptoms such as clicking, popping and catching. However given patients with OA experience mechanical symptoms, it would need to be clear that these were mechanical symptoms on the joint line.
- The issue of access to physiotherapy and variability of quality of physio across London was highlighted, CCGs don’t know the cost and value of physio treatment. There are often waiting

lists to access physio, which can often be of poor quality, and means that patients often get referred for surgery when they could have been effectively managed by better quality physio.

- It was noted that X-rays can be a very powerful screening tool as they clearly show whether the issue is the meniscus or arthritis. However, advocating the use of X rays would have an impact on the system.
- The group noted that there are known issues and poor practices around MRI scanning in interface services that need to be addressed. This means that patients may be diverted to an inappropriate surgical pathway, only to be told that they need physio.
- Given these issues, it was agreed that rather than stating '3 months', it may be more appropriate to state 'comprehensive', to ensure that there is a decent offer of conservative treatment.
- The Group noted that MSK services are patchy with considerable variation in the levels of access. The Group was informed that there is a NHSE London programme to ensure that MSK is in place across London. There is also a piece of work looking at bringing existing services up to a London wide standard in order to address the significant variation.
- It was suggested that the policy could include an "advice for primary care section" to reinforce key points raised in discussions for example, a meniscal tear can be asymptomatic and doesn't require surgery, an Xray is a better indicator of whether a meniscal tear needs surgery than an MRI etc.
- It was agreed that a shared decision making aide should be referred to in the policy, to inform discussions with patients. It was confirmed that the London Choosing Wisely programme did not have the resource to develop its own SDM tool. The Group agreed that a recommendation could be for CCGs to develop patient leaflets.
- In terms of the BASK classification of symptoms and signs, it may not be helpful to have a long list in the policy, so this should be reviewed. The top and bottom box indicators may be useful.
- It was agreed that the policy should be an additional nudge for clinicians to keep going in the right direction.
- It was agreed that the BASK work should be referenced in the policy.
- It was agreed that arthroscopy as part of another procedure should be excluded from the policy.
- It was highlighted that the surgeons do not have sight of the codes, the coding officer who codes the operation notes.
- The group reviewed the list of OPCS codes included from the national database and agreed to remove W892 and W871. There are a few codes used at North West London that are not on the list.
- It was suggested that the final policy should not only be shared with the CCGs, but sent to wider stakeholders including service managers at London NHS Trusts.

### **13. Review of the draft policy (statements above) against the ethical application sheet**

The statements and process were reviewed against the key principles and considerations of the ethical framework. The group agreed that decisions were:

- Rational: it was noted that whilst there is evidence underpinning the BASK paper, the Task and Finish Group have not yet had full sight of this; and national guidelines are limited. It was agreed that the Royal College of Physiotherapists should be included in the circulation list for the draft policy.

- Socially inclusive: age has been removed and there are no barriers in terms of duration / time.
- Clear and open to scrutiny
- Economic factors had been taken into account
- Promoted health: current support offers are not adequate but it was agreed that this was out of scope of the policy.

#### **14. Next steps**

- Deloitte will draft a policy based on the BASK chart and seek comment from Imran, Adil and Fares.
- Imran will send NWL codes to Deloitte to include in the revised policy.
- Deloitte will then revise the policy and will be circulated ahead of the next meeting on 23 May, where the policy will be reviewed and approved.

## Hip & Knee Arthroplasty and Knee Arthroscopy Task and Finish Group meeting, 23 May 2018

### Notes of key discussion points

#### Task and Finish Group members

Attendees:		
Adil Ajuied	Consultant Knee Surgeon / Senior Hon. Clinical Lecturer	SEL
Ethan Harris-Faulkner	GP Bexley	SEL
Imran Sajid (Chair)	GP and Chair, NWL Policy Development Group Governing Body Executive, West London CCG;	NWL
Jane Hopkins	Lay representative; lay advisor London Borough of Greenwich, Adultcare Transformation Group and Healthwatch Greenwich	SEL
Apologies		
Folake Segun	Chief Executive Healthwatch (Bromley and Lewisham) and Community Waves	SEL
Fares Haddad	Hip and Knee Reconstructive Surgeon	NCL
Maurice Sanomi	GP, Clinical Director Havering CCG	NEL
Rosie Andrews	Nurse / Public Health, Public Governor for Kings Health Care	

#### Also in attendance:

Pida Ripley	Patient Representative, British Orthopaedic Association Patient Liaison Group (BOA PLG)	London Choosing Wisely Steering Group
Jane Halpin	Director	Deloitte
Catharine Geldart	Senior Consultant	Deloitte
Danny Batten	Acting Director of Transformation and Delivery (NEL)	NHSE
Mandip Korotana	Programme Manager	Healthy London Partnership
Kunle Awosanya	Project Manager	Healthy London Partnership

#### 15. Welcome from Imran Sajid, Chair of the Task and Finish Group

The Chair welcomed members and outlined the purpose of the meeting. The Chair confirmed that:

- the meeting was quorate
- there were no conflicts of interest

#### 16. Agreement and sign off on notes of previous meetings

The notes of the meeting on 9 May 2018 were reviewed and agreed as an accurate and a true reflection of the meeting. Pida Ripley asked to include in her role: *British Orthopaedic Association*

Patient Liaison Group (BOA PLG); London Choosing Wisely Steering Group member. The group agreed to ratify the notes of the meeting.

The notes of the meeting on 16 May 2018 were reviewed and agreed as an accurate and a true reflection of the meeting. There were no comments or amendments.

### 17. Presentation of the draft policy for knee arthroscopy: Catharine Geldart and Jane Halpin

Colleagues from Deloitte presented the draft policy which had been revised following comments from members at the previous meeting. This had been circulated in advance to the Task and Finish Group members. The following key changes were highlighted:

- Section 4 Criteria for commissioning is the main area of change. It now incorporates the Treatment Guidance: Arthroscopic Meniscal Surgery guidelines due to be published by British Association for Surgery of the Knee (BASK) / British Orthopaedic Association (BOA), as per discussions at the last meeting.
- Exclusions are more detailed given the agreement to have a knee arthroscopy policy rather than meniscal disease policy.
- An advice for primary care practitioners section is included (similar to some of the other pan London policies) which captures additional details relating to pathology, diagnosis, referral and first steps of management and health optimisation measures, as discussed at the last meeting.

In terms of the commissioning criteria:

- This starts by stating clearly who the policy is for.
- The policy covers all knee arthroscopy interventions in degenerative knee diseases.
- It makes clear that patients with acutely locked knee should be referred for urgent management in accordance with the BOA publication.
- The commissioning criteria table below is the tick box specifically for meniscal interventions as well as meniscal repair and meniscectomy.

<b>In ordinary circumstances*, funding for knee arthroscopic meniscal interventions (meniscal repair or meniscectomy) is available for patients who meet ALL of criteria 1 and 2:</b>	
1a	Patient has a truly locked knee on examination (sudden onset, complete mechanical block to flexion or extension of the knee), which does not resolve with adequate analgesia <b>OR</b>
1b	Patient has a confirmed or suspected symptomatic “target” lesion (see below for definitions)
2a	The patient gives a clear history in keeping with meniscal pathology e.g. clicking, catching or popping sensation along the joint line (see below for definitions) <b>AND</b>
2b	The patient has engaged with a comprehensive programme of non-surgical management, including education, simple analgesia, exercise and physiotherapy <b>AND</b>
2c	Consideration has been given to the degree of osteoarthritis present**

- As agreed at the last meeting, patients would need to meet criteria 1a or 1b as well 2a and 2b and 2c above to be eligible for funding.
- Additional sections have been included to elaborate further on these criteria as follow:

- Referral/treatment outside of these criteria should refer to the CCG Individual Funding Request policy
  - Patients with advanced structural osteoarthritis (OA) are usually not appropriate for arthroscopic meniscal surgery, except in rare cases of a suspected target lesion.
  - The assessment of OA is superior with appropriate standing x-rays compared with MRI, which should not be routinely requested in these cases.
  - Arthroscopic lavage and debridement in patients with knee OA will not be routinely funded, except in the few patients with a clear history of true mechanical locking
  - Arthroscopy will not be routinely funded for the treatment of OA (other than in the circumstances above).
  - The use of arthroscopy for primary diagnostic purposes will not be routinely funded.
- The addition of definitions, case studies and classification of symptoms and signs should be helpful in primary care when considering referring patients. These have been extracted from the BASK guidelines.

## 18. Drafting the London policy

Group discussions started with the criteria:

- It should be clear that 1a is about a truly locking knee, and not be confused with an acute locked knee that requires urgent referral.
- The group agreed to move 1b into section 2 so the criteria would read as 1a OR 1b AND 2a AND 2b AND 2c.
- There was a discussion about criteria 2c and how easy is it would be to implement and whether the wording was sufficiently robust. It was agreed that 2c is a nudge for good practice, and should be reworded to ensure it is easy to use but may be difficult to measure.
- The group discussed whether it would work better if 2c became 3.

The Chair then led discussions on translating BASK/BOA Guidelines on treatment of meniscal disease into a mandated commissioning policy as follows:

- The Chair expressed uneasiness about incorporating these guidelines into a policy given that the evidence behind the guidelines is not yet published and therefore not available to be reviewed and scrutinised by the group. .
- Whilst it was acknowledged that at the last meeting, the Group had agreed to use the BASK Guidelines to develop parts of the policy (specifically relating to arthroscopic meniscal interventions), on reflection, the Chair was now concerned about the robustness of this approach given that the agreed policy (once adopted by CCGs) will be mandatory.
- The Group had agreed to take a pragmatic approach at the last meeting, to use these Guidelines to address variation in practice.
- From a commissioner's perspective, the justification and origin of the policy could be questioned and challenged given that the evidence behind the guidance has not been available to be scrutinised by the Group.

- From a surgeon perspective, they would refer to their professional bodies for best practice. However it is possible that other academic groups could challenge or disagree with the work.
- It was noted that the evidence will be published in 3 – 6months. In deriving the guidance, the BOA/BASK conducted a full systematic review, the results of which were inconclusive. As a result, a consensus group was formed comprising of 24-26 knee surgeons across UK, each with more than 10 years of consultant experience. They held four meetings to consider potential scenarios and score on how likely they would be to offer surgery. Areas of consensus were noted, and grey areas were discussed. The guideline that will be published will be a consensus piece, and will kick start a prospective randomised control trial to assess conservative vs surgical treatment in the management of joint-line focussed pain and mechanical symptoms However the results of this trial will not be available for several years.
- It was noted that other Task and Finish groups have also had difficulties where there is little or no evidence and some have taken a pragmatic approach, incorporating what is understood to best practice as advised by the professionals at the meeting, especially where this may reduce demand for inappropriate treatment.
- The Group could therefore agree whether they take a pragmatic approach, or agree that as the evidence is not available, they cannot proceed further.
- The area of contention is about the patient group who are symptomatic with a meniscal target (box 4 in the flow chart), where there is limited evidence for effectiveness of arthroscopic meniscal surgery. There is no dispute that surgical intervention is indicated in cases of acute injury and an acutely locked knee. There is also no dispute that arthroscopy is not indicated in the routine treatment of OA.
- There appeared to be two options available to the Group: incorporate the BASK guideline into the policy or remove references to meniscal work in the policy and revert to the initial proposed policy scope of arthroscopic lavage & debridement in OA.
- The Group considered whether the BASK guidelines could be used as a ‘position statement’ or strong recommendation in the policy, rather than as commissioning criteria.
- They agreed that a significant “nudge” opportunity (to encourage greater consistency of practice) might be missed if the BASK/BOA guidelines were not included in the policy in some form.
- The BASK/BOA guidelines are trying to address the variation that currently exists.
- There was agreement that variation in practice was an issue, but also concern about translating guidelines into a PPwT policy, from a process perspective.
- The policy could therefore focus on ‘arthroscopy for OA is not routinely funded unless the following criteria apply’ as per the original scope, and refer to the BASK guidelines in the form of a position statement.
- There was a discussion about what added value a pan London policy would add if it was limited in this way. The Group noted that whilst South West London and North West London already have policies onmeniscal surgery, the remaining London CCGs do not.
- There were concerns that a position statement or reference to BASK guidelines would not be observed and would therefore have no impact.
- The Group took a vote and the majority view was to proceed with the original scope but include a position statement within the policy, rather than incorporating BASK guidelines into the policy itself. The commissioning criteria would therefore say ‘ arthroscopy for

treatment of OA, except in the presence of a target lesion, is not routinely funded'. There would be reference to the BASK guidelines.

- The Group noted that the NICE Guidelines were somewhat outdated and proposed following terminology:
  - Recent history of loss of terminal extension, rather than 'target lesion'
  - Loose body pathology
  - Significantly mechanically symptomatic menisci tear or chondral flap which has been symptomatic for 6-12 weeks despite conservative treatment
  - Locked knee: loose body or misplacement of meniscal tissue
- The Group noted that a significant change had been proposed to the draft policy, which was contra to discussions at the last meeting, and that some members were not present at this meeting and thus unable to participate in the discussion about these change of viewpoint.

### 19. Next steps

- The Task and Finish Group Chair will email members to update on the discussion and proposal, and ask for comments, particularly from those not present.
- The policy will be re-drafted accordingly and circulated to Task and Finish group members for comments and agreement over email.