Derby and Derbyshire
Integrated Care Board

CLINICAL POLICY ADVISORY GROUP (CPAG)

Diagnostic Knee Arthroscopy Policy

Statement

Derby and Derbyshire ICB, in line with its principles for procedures of limited clinical value has deemed that **Diagnostic Knee Arthroscopy** should not routinely be commissioned unless the criteria within this policy are met.

The majority of patients who present to primary care with knee pain will not require any further investigation (such as MRI or Arthroscopy).

Diagnostic Knee Arthroscopy will only be funded in patients:

- With clear history of mechanical symptoms e.g. locking that have not responded to at least 3 months of non-surgical treatment
  AND
- Where a detailed understanding of the degree of compartment damage within the knee is required, above that demonstrated by imaging, when considering patients for certain surgical interventions (e.g. high tibial osteotomy)

A Diagnostic Knee Arthroscopy should not be undertaken on patients who then require a Total Knee Replacement within one year.

These commissioning intentions will be reviewed periodically. This is to ensure affordability against other services commissioned by the ICB.

1. Background

A Diagnostic Knee Arthroscopy is a surgical procedure that allows for the inspection of the knee joint without making a large incision through the skin and soft tissues. It is used to diagnose problems in the knee joint. It has been used extensively in the past to diagnose knee problems, but this is no longer appropriate due to the invasive nature of the procedure and the increasing access to less invasive diagnostic methods such as MRI.

An arthroscopy is generally considered to be a safe procedure, but like all types of surgery there's a risk of complications. It's normal to have short-lived problems such as swelling, bruising, stiffness and discomfort after an arthroscopy. These usually improve in the days and weeks after the procedure.

This policy should be read in conjunction with other DDICB Orthopaedic Policies:

- Arthroscopic Knee Washout for Patients with Osteoarthritis
- Arthroscopic Surgery for Degenerate Meniscal Tears

2. Recommendation

The majority of patients who present to primary care with knee pain will not require any further investigation (such as MRI or Arthroscopy).

Diagnostic Knee Arthroscopy will only be funded in patients:

- With clear history of mechanical symptoms e.g. locking that have not responded to at least 3 months of non-surgical treatment
  AND
- Where a detailed understanding of the degree of compartment damage within the knee is required, above that demonstrated by imaging, when considering patients for certain surgical interventions (e.g. high tibial osteotomy)

A Diagnostic Knee Arthroscopy should not be undertaken on patients who then require a Total Knee Replacement within one year.

3. Rationale for Recommendation

The majority of patients who present to primary care with knee pain will not require any further investigation (such as MRI or Arthroscopy).

NICE recommends that osteoarthritis can be clinically diagnosed without investigations if a person:

- is 45 or over and
- has activity-related joint pain and
- has either no morning joint-related stiffness or morning stiffness that lasts no longer than 30 minutes.

The BASK-BOA-RC Commissioning Guide advises that:

- Knee arthroscopy should only be considered in patients:
  - With clear history of mechanical symptoms e.g., locking that have not responded to at least 3 months of non-surgical treatment **AND**

- Where a detailed understanding of the degree of compartment damage within the knee is required, above that demonstrated by imaging, when considering patients for certain surgical interventions (e.g., high tibial osteotomy)

GIRFT Orthopaedics Report 2015 concluded that:

- Knee arthroscopy was not a clinically effective intervention for many patients with knee osteoarthritis
- It is not good practice, nor cost effective if a high number of arthroscopies are being undertaken on patients who then require a TKR within one year

4. Personalised Care

Personalised care simply means that people have more control and choice when it comes to the way their care is planned and delivered, considering their individual needs, preferences and circumstances. It includes supporting shared decision making and self-management.
Shared decision-making means people are supported to:

- *understand the care, treatment and support options available and the risks, benefits and consequences of those options*
- *decide on a preferred course of action, based on evidence based, good quality information and their personal preferences.*

Supported self-management means increasing the knowledge, skills and confidence a person has in managing their own health and care. This involves using self-management education, peer support, and health coaching.
Decision support tools, also called patient decision aids support shared decision making by making treatment, care and support options explicit. They provide evidence-based information about the associated benefits/harms and help patients to consider what matters most to them in relation to the possible outcomes, including doing nothing.

5. Useful Resources

- NHS Website: Arthroscopy. https://www.nhs.uk/conditions/arthroscopy/
- BRAN leaflet – Shared decision making supports individuals to make the right decision for them. This easy-to-use leaflet supports this people to consider their treatment options.

6. References

- NICE Guidance CG177. Osteoarthritis: Care and Management https://www.nice.org.uk/guidance/CG177
- Royal College of Surgeons Commissioning Guides: Painful Osteoarthritis of the Knee July 2017 https://www.rcseng.ac.uk/-/media/files/rcs/standards-and-research/commissioning/boa--painful-oa-knee-guide-final-2017.pdf
- Getting It Right First Time (GIRFT). A national review of adult elective orthopaedic services in England. March 2015. https://gettingitrightfirsttime.co.uk/wp-content/uploads/2017/06/GIRFT-National-Report-Mar15-Web.pdf
- Getting it Right First Time (GIRFT). February 2020. Getting It Right in Orthopaedics. A follow up. https://gettingitrightfirsttime.co.uk/wp-content/uploads/2020/02/GIRFT-orthopaedics-follow-up-report-February-2020.pdf

7. Appendices

Appendix 1 - Consultation

All relevant providers/stakeholders will be consulted via a named link consultant/specialist. Views expressed should be representative of the provider/stakeholder organisation. CPAG will consider all views to inform a consensus decision, noting that sometimes individual views and opinions will differ.

Consultee	**Date**
Consultant Orthopaedic Surgeon, UHDBFT	March 2022
Clinical Policy Advisory Group (CPAG)	April 2022
Clinical and Lay Commissioning Committee (CLCC)	May 2022
Consultant Orthopaedic Surgeon, CRHFT	December 2024
Orthopaedic Clinical Director, CRHFT	December 2024
Consultant Trauma & Orthopaedic Surgeon, UHDBFT	December 2024
Clinical Policy Advisory Group (CPAG)	December 2024

Appendix 2 - Document Update

Document Update	**Date Updated**
Version 1.0	April 2022
Version 1.1 • In line with risk profile, CPAG agreed to extend the review date of this policy by 3 years, in agreement with clinical stakeholders, due to reduced capacity within the Clinical Policies team. • Addition of 'Personalised Care' section. • Reference to BRAN leaflet added to 'Useful Resources' section.	December 2024