

Joint Approach

The newsletter of the National Joint Registry

Contents

Annual Report highlights **2-3**

NJR PROMS **3**

Day in the life of a physiotherapist **4**

7th Annual Report shows record reporting rate



© Chris Phan (licensed CC-BY)

Clyde Auditorium: conference venue.

The NJR's 7th Annual Report shows record compliance levels, when compared to implant sales. The 98% figure for 2009 takes total coverage for all procedures since the NJR began, in 2003, to 82%.

The Annual Report was launched on 15th September at the 12th meeting of the Combined Orthopaedic Associations in Glasgow (COMOC 2010). The report's clinical findings were presented by the surgeon members of the NJR Steering Committee; Professor Paul Gregg, Mr Martyn Porter and Mr Keith Tucker.

Annual variations in implant sales have had a significant influence on the headline compliance figure in the past three years. Nevertheless, the trend shows NJR compliance continues to improve year-on-year.

For the first time, 2009 saw more cementless hip replacements than cemented procedures, despite evidence of superior short-term results for cemented total hip replacements.

...See page 2 for more details of the Annual Report.

New Government endorses NJR

As the Government sets out its healthcare strategy for the coming term, it has highlighted the NJR as a best practice example of measuring quality to improve patient outcomes.

Addressing the British Medical Association (BMA) in June, Secretary of State for Health Andrew Lansley CBE told delegates the coalition would focus solidly on patient engagement and empowering clinicians in order to improve healthcare outcomes.

"Better information means better care," Lansley said. "In England and Wales, our own National Joint Registry opened in 2003 and it is now delivering feedback to clinicians to help improve the quality and outcomes of hip and knee replacement operations.

"It should become a basis for quality and outcomes measurements and for information to patients to support choice."



© Department of Health

Health Secretary: Andrew Lansley.



National Joint Registry

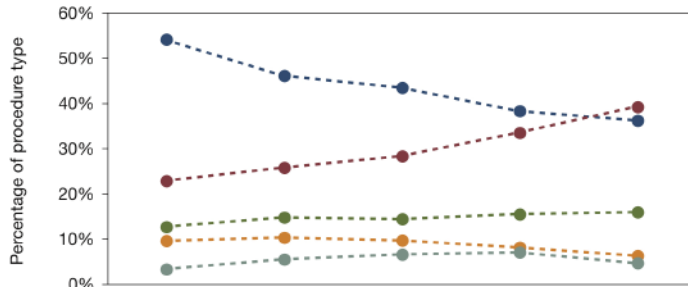
www.njrcentre.org.uk

■ Annual Report highlights

Cementless hip replacements overtake cemented

Figure 2.3

Type of primary hip replacement procedures undertaken between 2005 and 2009.



	2005	2006	2007	2008	2009
● - Cemented	54%	46%	43%	39%	36%
● - Cementless	22%	25%	28%	33%	39%
● - Hybrid	12%	14%	14%	15%	15%
● - Resurfacing	9%	10%	9%	8%	6%
● - Large head with resurfacing cup	3%	5%	6%	7%	4%
Number of procedures	56,229	59,547	66,315	68,976	65,229

Year



Surgeons increasingly favour cementless hip replacements.

For the first time, the number of cementless hip replacements has overtaken cemented procedures, analysis in the 7th Annual Report shows. Despite evidence of superior short-term results for cemented total hip replacements, the proportion of procedures using cement continues to fall year-on-year.

Cementless hip replacements have increased, as a proportion of all primary hip replacements performed, from 22% in 2005 to 39% in 2009. Over the same period, cemented procedures have fallen from 54% to 36%. Hybrid fixation has increased from 12% to 15%.

By contrast, the type and fixation of knee replacements has remained largely unchanged over the lifespan of the NJR. Cemented total knee

replacements continue to dominate with an 83% share. Cementless total knee replacements represented only 6% of primary knee replacements.

NJR Steering Committee Acting Chair Professor Paul Gregg said:

“Patients and surgeons have always looked to new prostheses to improve outcomes. These trends obviously emphasise the importance of the NJR in determining whether newer prostheses do in fact perform better. Perhaps now that the number of cementless hip replacements is greater than the number of cemented, the time has come to step back and have a thorough reassessment.”

For more detailed information about the figures quoted and how they were calculated, please refer to the Annual Report which is available as a download from the NJR website: www.njrcentre.org.uk

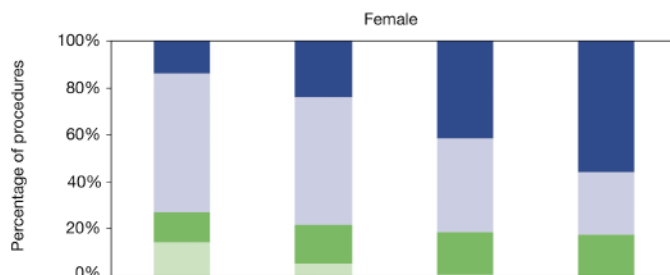
Other clinical highlights

- The overall revision rate following primary hip replacement was 1.0% at one year, 2.1% at three years and 2.9% at five years. Five-year revision rates were lowest, at 2.0%, for those patients who received a cemented prosthesis and highest, at 7.8% for large head metal on metal total hip replacements.
- The overall revision rate following primary knee replacement was 0.7% at one year, 2.5% at three years and 3.6% at five years. Five-year revision rates were lowest, at 3.0%, for those patients who received a cemented prosthesis and highest, 9.4%, for those who received a unicondylar knee replacement.
- Hip resurfacing declined from 5,707 procedures in 2008 to 4,099 in 2009.
- There is an increasing trend to use larger head devices for hip replacements. In 2009, 26% were 36mm or above, compared with 20% in 2008 and only 1% in 2003.
- This year's report includes a breakdown of bi-condylar primary knee replacements by constraint. Just over 72% were cruciate retaining, 25% posterior stabilised, 3% constrained condylar and less than 1% were hinged or link knee replacements.

Age and gender influence operation type

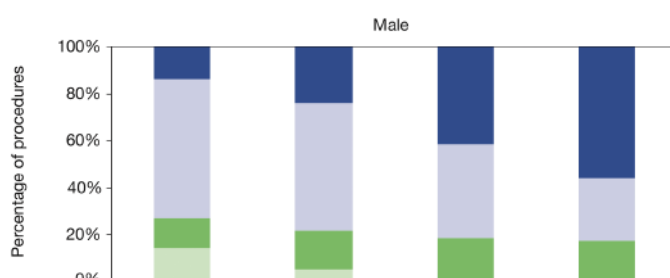
Figure 2.4(a)

Age and gender for primary hip replacement patients in 2009.



Age group	<55	55 - 64	65 - 74	75+
Cemented	14%	24%	42%	56%
Cementless	59%	54%	40%	26%
Hybrid	13%	17%	18%	17%
Resurfacing	14%	5%	1%	<1%
Number of patients	3,638	7,727	12,831	12,223

Age group



Age group	<55	55 - 64	65 - 74	75+
Cemented	10%	18%	34%	50%
Cementless	48%	52%	47%	32%
Hybrid	9%	12%	16%	17%
Resurfacing	33%	18%	3%	<1%
Number of patients	3,829	6,450	8,441	6,075

Age group

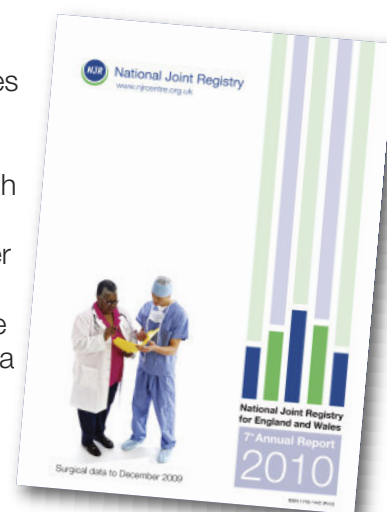
A patient's age and gender play a significant role in determining the type of joint replacement performed, figures in the 7th Annual Report suggest.

In 2009, fewer than 1% of hip replacement patients over 75 had a hip resurfacing. In contrast, among patients under 55, 33% of men and 14% of women underwent hip resurfacing.

Cemented total hip replacement (THR) is more common in older patients. 50% of male patients over 75 had a cemented THR, compared to only 10% for men under 55. Among female patients over 75, 56% had a cemented THR, compared to 14% for the under 55s.

In knee replacement surgery, only 3.5% of patients over 75 had a unicondylar knee replacement, which replaces only half the joint. This compares with 20.5% of patients under 55. Overall, men are more likely to have a unicondylar replacement than women.

© National Joint Registry 2010



NJR PROMs to examine patient outcomes

The NJR is set to embark on a project to examine long-term patient-reported outcomes. Patients in the study, starting in October, will have the opportunity to give feedback up to five years after their operation.

The new project builds on the work of the Department of Health Patient Reported Outcome Measures (PROMs) in England, which record NHS patient outcomes six months after surgery. Around 35,000 patients who have taken part in the NJR and the national PROMs questionnaires will be invited to record their progress at one year, three years and five years.

By providing clinicians with more complete information about the outcomes of surgery, PROMs will help them to improve patient care in the future.

NJR Steering Committee patient representative Mary Cowern said:

"This is a great opportunity to understand the outcomes of joint replacement surgery from a patient perspective over a much longer period than we have before."

■ A Day in the Life of a physiotherapist

Toni Kenwright is a physiotherapist at the Cheshire and Merseyside NHS Treatment Centre in Runcorn in Cheshire. She tells Joint Approach about a typical day on the ward.

My day can start as early as 8am with a handover from the nursing team. They tell us how the patients have been and whether there have been any problems; pain, struggling to get in or out of bed – anything really that we need to be made aware of.

Typically, the first patients we see are those who had surgery the day before. We do their full exercises with them and get them mobile. We aim to get them sitting in a high-back, sturdy chair – but it does not always work out that way. We take it nice and slowly on day one – the patients can become light-headed!

Next, we see the patients who are ready for discharge. We liaise with the doctors and nurses to make sure they are medically fit for discharge, if we feel they are physically ready for home. It is very important for us to establish that the patients are aware of what they can and cannot do once they return home. If they need social services or further rehabilitation, that will be

arranged. We send a discharge summary to the local physiotherapist who will be seeing the patient after they have left hospital and arrange a follow up for the patient to come back to see us at the Treatment Centre at three weeks post-operatively.

Finally, we see the remaining 'day two' and 'day three' patients and any medically fit patients who have just had surgery. They will be encouraged to continue with their exercises and progressed on to elbow crutches as able. They are assessed on the stairs and also step mobility. We also have many other duties including checking the patient advice line, making sure there is plenty of stock, preparation of the documentation packs and so on. The largest part of my typical day is patient care. Seeing the patients develop and gain confidence in their new joints is the most satisfying.



Toni Kenwright

Extracts from an interview with Toni Kenwright. Words edited by Joint Approach for space and clarity.

■ Trainee registration essential

Failure to register trainee surgeons on the NJR may be preventing them from getting the benefits of the Registry. NJR data is used by trainees during interviews as evidence of their practice, but these figures are not available where the surgeon has not been registered.

Where specialty registrars are operating, entering their procedures in the name of the consultant could also distort surgeon outcomes measures.

In most cases, the Hospital Data Manager may add a surgeon to their hospital without reference to the Service Desk.

The NJR Centre recommends registration on the NJR be incorporated into the induction process for trainees. If you need help or advice regarding this process, please contact your Regional Co-ordinator.

If you would like to make a contribution to *Joint Approach* or have suggestions about subjects you would like to see in a future issue, please contact the NJR Helpline or email the Service Desk.

All NJR information and documents are available on the NJR website.

Alternatively, contact the NJR Helpline to receive copies by email or post.

If you have any queries, please contact us via:

The NJR Centre, Peoplebuilding 2, Peoplebuilding Estate, Maylands Avenue, Hemel Hempstead HP2 4NW

NJR Helpline: 0845 345 9991

Email: health_servicedesk@northgate-is.com

Website: www.njrcentre.org.uk