Knee Replacement Waiting Lists

Clinically governed medical travel to India as a viable, safe and affordable option

A patient and referrer briefing for UK knee replacement patients considering alternatives while waiting for NHS care

Core message

For suitable patients, a clinically governed, doctor-led medical travel pathway can offer timely access to knee replacement surgery in India while maintaining strong safeguards around assessment, hospital selection, consent, infection prevention, post-operative recovery, records transfer and UK-facing follow-up. It is not a replacement for urgent NHS care, and it is not appropriate for every patient.

At a glance

The problem	The TMTC response	The governance principle
Long waits for elective knee replacement can worsen pain, mobility and quality of life.	A structured India pathway can provide faster access for suitable self-pay patients.	Speed must never bypass clinical assessment, consent, safety checks or continuity of care.
UK private knee replacement can be expensive for many patients.	India may offer high-quality orthopaedic care at a materially lower package cost.	Affordability must be transparent: surgery, hospital stay, recovery, travel, insurance and contingency planning.
Medical travel can feel risky if poorly coordinated.	TMTC can coordinate named doctors, hospital due diligence, recovery support and UK communication.	Patient safety depends on clear accountability before travel, in India and after return to the UK.

1. Why this matters now

Many UK patients waiting for knee replacement are not simply waiting for an operation; they are living with pain, reduced walking distance, sleep disruption, loss of independence and a gradual decline in fitness. The waiting period can also make eventual recovery harder if muscle strength, weight, confidence and mobility deteriorate.

The NHS Referral to Treatment standard states that patients should wait no longer than 18 weeks from GP referral to treatment, although orthopaedic waits can be longer depending on local capacity, clinical priority and provider availability. The TMTC article notes that many patients may face waits of 12-18 months, and in some regions longer, for routine knee replacement surgery.

This creates a practical question for suitable patients: is there a clinically responsible alternative that is faster than waiting, more affordable than UK private surgery, and safer than uncoordinated medical tourism?

The answer

Yes - but only if the pathway is clinically governed. The safety case is not simply "India is cheaper". The safety case is that the patient is assessed properly, treated by an appropriately credentialed surgeon in a vetted hospital, supported through recovery, given clear records and discharge information, and connected back into UK follow-up arrangements.

2. The case for India - but not ordinary medical tourism

India has a large, mature orthopaedic market, high-volume joint replacement surgeons, internationally recognised hospitals and many clinicians with UK or international training. For the right patient, this can make India a serious treatment destination rather than a price-led compromise.

However, knee replacement is major surgery. It involves anaesthesia, implants, thromboprophylaxis, infection prevention, physiotherapy and careful discharge planning. A safe proposition must therefore be built around clinical governance rather than travel logistics alone.

- The patient should have a named surgeon and a clearly identified treating hospital.
- The indication for surgery should be reviewed against symptoms, X-rays, conservative treatment and patient goals.
- The patient should receive a realistic explanation of benefits, alternatives and risks before committing.
- The implant choice, theatre standards, infection control policies and blood clot prevention plan should be understood.
- The recovery plan should include physiotherapy, wound monitoring, medication guidance and escalation routes.
- The return-to-UK plan should be documented before the patient travels.

3. What makes a pathway clinically governed?

A clinically governed medical travel pathway should be designed in the same spirit as a UK independent sector pathway: suitability screening, practising privileges, consent, safety checks, audit, complications planning and clear patient communication.

Governance domain	What TMTC should make explicit for knee replacement patients
Patient suitability	Clear inclusion and exclusion criteria, including BMI, diabetes control, cardiac/respiratory risk, previous DVT/PE, infection risk, frailty, anaesthetic risk and ability to participate in rehabilitation.
Surgeon credentialing	Verification of qualifications, specialist registration where relevant, operative experience, complication profile, peer references and hospital practising privileges.
Hospital due diligence	Hospital accreditation, theatre standards, sterilisation processes, ICU availability, infection control protocols, blood bank access and emergency escalation arrangements.
Consent and shared decision-making	Written consent covering procedure, alternatives, implant choices, anaesthesia, DVT/PE, infection, stiffness, nerve/vessel

	injury, persistent pain, revision surgery and death.
Implant and registry records	Documented implant make, model, batch/lot numbers and operative record for the patient and UK clinicians.
Rehabilitation and discharge	A physiotherapy-led recovery plan, wound care instructions, medication plan, red flags and written discharge summary.
Complications pathway	Named contacts, response times, insurance terms, private UK review options and criteria for urgent NHS/A&E attendance.
Audit and learning	Outcome tracking, patient-reported outcome measures, complications review and governance oversight by a medical advisory structure.

4. Patient pathway: from UK enquiry to recovery

A safe TMTC pathway should feel structured from the first conversation. Patients should know who is responsible, what information is needed, how decisions are made and what happens if something does not go to plan.

1. Initial enquiry and triage: Patient goals, pain severity, walking distance, X-rays, co-morbidities, medications and red flags are collected. Patients with urgent or unstable symptoms are directed to NHS urgent care rather than medical travel.

2. Clinical records review: Relevant notes, imaging and medication history are reviewed. Missing information is requested before any treatment plan is presented.

3. Surgeon matching and treatment plan: The patient is matched to an appropriate orthopaedic surgeon and hospital in India. The plan should state whether total, partial or robotic-assisted knee replacement is being considered.

4. Transparent quotation: The patient receives a clear package price and understands what is included and excluded: consultation, surgery, implant, hospital stay, physiotherapy, accommodation, flights, medications, aftercare and insurance.

5. Pre-operative optimisation: Weight, smoking, diabetes, dental/skin infection, anaesthetic fitness, blood tests and thrombosis risk are addressed before travel.

6. Travel and admission: TMTC coordinates arrival, transfers, hospital admission, translator/support if required and pre-operative checks.

7. Surgery and inpatient recovery: The operation is performed by the named team with standard infection prevention, anaesthesia, pain relief and DVT prophylaxis. Early mobilisation begins with physiotherapy.

8. Step-down recovery and physiotherapy: The patient enters a structured recovery phase with wound checks, mobility milestones and exercise progression.

9. Return to the UK: The patient travels only when clinically fit to fly and receives discharge documents, implant details, medication plan and red-flag guidance.

10. UK-facing follow-up: Follow-up is coordinated through TMTC, private UK GP/specialist review where appropriate, and the patient is discharged back to routine NHS GP care when stable.

5. Safety: the key risks and how governance reduces them

No pathway can remove the risks of knee replacement. The responsible message is that risks should be identified, explained, reduced where possible and managed early if they occur.

Risk	Why it matters	Governance control

Infection	Can require antibiotics, washout surgery, prolonged treatment or revision.	Hospital infection-control due diligence, pre-op screening, antibiotic prophylaxis, wound monitoring, red-flag escalation and clear aftercare.
DVT/PE	Long-haul travel and major lower-limb surgery both increase thrombosis risk.	Individual risk assessment, anticoagulation plan, stockings/pumps where appropriate, early mobilisation and fit-to-fly decision-making.
Medical deterioration	Co-morbidities can increase anaesthetic and surgical risk.	Pre-op optimisation, anaesthetic review, ICU access and exclusion of patients who are not suitable for travel surgery.
Poor rehabilitation	Outcomes depend heavily on physiotherapy and patient engagement.	Structured physiotherapy, milestones, pain control, exercise guidance and remote/UK follow-up.
Communication gaps	UK clinicians need accurate records if the patient needs help after return.	Discharge summary, operation note, implant details, medication list, imaging and contact details for the treating team.
Financial surprises	Unplanned costs can cause distress.	Transparent quotation, exclusions, contingency planning and post-surgery insurance clarity.

Important safety statement

Patients should not travel for surgery if they are medically unstable, have active infection, uncontrolled co-morbidities, unresolved anaesthetic concerns, unrealistic expectations, inadequate home support, or cannot safely comply with rehabilitation and follow-up.

6. Affordability: value, not just low cost

The TMTC article indicates that UK private knee replacement commonly costs in the region of £10,000-£15,000. Medical travel to India may be more affordable, but the right comparison is not simply operation price versus operation price. A responsible comparison includes the total pathway cost and the safeguards wrapped around the operation.

Option	Typical advantage	Common limitation	Patient question to ask
NHS knee replacement	No direct cost to patient; established pathway.	Wait may be long depending on provider and priority.	Can I be referred to a provider with a shorter wait?
UK private knee replacement	Fast access and UK-based follow-up.	Often expensive for self-pay patients.	What is included in the package and what is extra?
Uncoordinated overseas surgery	Potentially lower headline price.	Higher risk of gaps in governance, aftercare and records.	Who is clinically accountable if something goes wrong?
TMTC clinically governed pathway	Potentially faster and more affordable, with structured travel, recovery and UK-facing support.	Not suitable for every patient; requires careful screening and informed consent.	What are the clinical checks, insurance terms and complication pathway?

7. Why TMTC can be positioned differently

TMTC should avoid being framed as a conventional medical tourism company. The stronger positioning is clinically governed, UK-facing medical travel: a pathway built around doctor oversight, patient selection, Indian hospital capability, recovery support and continuity back to the UK.

- UK-facing clinical guidance and communication before the patient travels.
- Personalised treatment planning rather than a generic package sale.
- Named Indian specialist and hospital with documented due diligence.
- Concierge coordination that reduces travel friction without replacing clinical judgement.
- Recovery and aftercare support in India before return to the UK.
- Post-surgery insurance and a documented approach to complications after return.
- Clear communication with UK GPs, physiotherapists and private clinicians where appropriate.

8. Suggested patient-facing explanation

Plain English wording

If you are waiting a long time for knee replacement surgery and your pain is affecting your life, clinically governed treatment in India may be an option to consider. TMTC is designed to make medical travel safer by

coordinating assessment, named specialists, hospital due diligence, recovery support and follow-up planning. It is not suitable for everyone, and the decision should be made only after your medical history, X-rays, risks, alternatives and recovery needs have been properly reviewed.

9. Suggested GP / physiotherapist / referrer wording

Professional wording

TMTC should be considered only as a structured self-pay option for suitable patients who are exploring alternatives to long elective orthopaedic waits. The important distinction is governance: patient selection, named clinicians, hospital due diligence, informed consent, infection and thrombosis risk management, discharge records, rehabilitation planning and a clear UK-facing complications pathway.

10. Patient questions before choosing medical travel

- Who is my named surgeon and what is their experience with knee replacement?
- Which hospital will I be treated in and what accreditation or quality standards does it hold?
- What implant will be used and will I receive implant traceability details?
- What is my personal risk of infection, DVT/PE, stiffness, persistent pain or revision surgery?
- How long will I stay in hospital and in step-down recovery before flying home?
- What physiotherapy will I receive in India and what is expected when I return to the UK?
- What exactly is covered by post-surgery insurance and what is excluded?
- Who do I contact if the wound becomes red, hot, swollen, painful or starts leaking?
- Will my UK GP receive a clear discharge summary and operation note?
- What happens if I am not fit to fly home as planned?

11. Recommended governance documents for TMTC knee replacement pathway

To make the proposition robust for patients, referrers and insurers, TMTC should maintain a clear document pack. This also strengthens trust and differentiates TMTC from price-led overseas surgery providers.

- Patient suitability and exclusion criteria for knee replacement abroad.
- Orthopaedic surgeon practising privileges and credentialing policy.
- Hospital due diligence checklist.
- Knee replacement patient information leaflet and consent form.
- Pre-operative optimisation checklist.
- Implant traceability and operative record template.
- Physiotherapy and rehabilitation protocol.
- Fit-to-fly and travel thrombosis risk protocol.
- Complications and escalation policy, including UK-facing review routes.
- Insurance summary written in plain English.
- Data sharing and medical records transfer consent.
- Patient-reported outcome and satisfaction audit process.

12. Balanced conclusion

Clinically governed medical travel to India can be a viable, safe and affordable option for selected UK patients waiting for knee replacement - provided the pathway is built around clinical judgement, not simply speed or price.

The strongest TMTC message is therefore: faster access, lower overall cost and a more supported experience, with governance safeguards that patients, families, GPs, physiotherapists and insurers can understand.

The aim should not be to persuade every patient to travel. The aim should be to help the right patient make an informed decision, with the right surgeon, in the right hospital, at the right time, with the right recovery and follow-up plan.

TMTC positioning line

A clinically governed bridge between UK patient need and high-quality Indian surgical expertise - designed to reduce waiting, protect safety, support recovery and make private treatment more affordable.

Sources and evidence base

1. The Medical Travel Company, “Knee Replacement on the NHS: How Long Is the Wait and What Can You Do While Waiting?”, 4 May 2026.
2. NHS England, Referral to Treatment: the NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.
3. NHS, Guide to NHS waiting times in England: maximum waiting time for non-urgent consultant-led treatments is 18 weeks, subject to exceptions.
4. NHS, Knee replacement recovery and complications information: most people have no complications, but risks include infection, blood clots, stiffness, persistent pain and other surgical complications.
5. National Joint Registry, Annual Report 2025: evidence base and registry reporting for joint replacement activity, implant and hospital outcomes.
6. The Medical Travel Company, Orthopaedic page: describes personalised orthopaedic pathways, post-surgery insurance and UK-facing complication support.
7. The Medical Travel Company, “How to Choose the Right Medical Travel Company for Your Treatment”: describes UK guidance, concierge coordination, hospital selection and aftercare in India.

Clinical disclaimer

This document is a strategic patient-information and pathway briefing. It is not a substitute for personalised medical advice, specialist orthopaedic assessment, anaesthetic assessment or legal/regulatory advice. Patients should seek individual advice from appropriately qualified clinicians before making decisions about surgery or travel.