

2013

Commissioning guide:

Pain arising from the hip in adults

Sponsoring Organisation: British Hip Society (BHS), British Orthopaedic Association (BOA), Royal College of Surgeons (RCSEng)

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Introduction

This guidance addresses the management of painful hip disorders in adults. The commonest cause is osteoarthritis.

Around 450 patients per 100,000 population will present to primary care with hip pain each year.¹ Of these, 25% will improve within three months and 35% at twelve months²; this improvement is sustained.³

Pain felt around and attributed to the hip can also be due to spinal or abdominal disorders which should be excluded. Hip pathology may cause pain felt only at the knee.

In the young adult, Femoroacetabular impingement (FAI), labral tears and hip dysplasia may cause hip pain, usually felt in the groin.

Trochanteric pain with local tenderness, is often due to trochanteric bursitis or abductor tendinopathy. Isolated trochanteric pain due to bursitis or tendinopathy settles in 64% after one year and 71% after five years.⁴

Degenerative hip disease is the most common diagnosis in the adult and is the long-term consequence of predisposing conditions.

Inflammatory joint disease of the hip may develop at any age, alone or with other joint involvement and may be due to auto-immune disease.

Osteoarthritis (OA) of the hip describes a clinical syndrome of joint pain accompanied by varying degrees of functional limitation and reduced quality of life.⁵

Osteoarthritis may not be progressive and most patients will not need surgery, with their symptoms adequately controlled by non-surgical measures. Symptoms progress in 15% of patients within 3 years and 28% within 6 years.⁴

The current hip scoring tools are not appropriate for use in prioritisation or deciding on referral thresholds.⁶⁻⁹

Total Hip Replacement (THR) is cost effective, returning 90% of patients to their previous job, and enabling the elderly to keep independent. The National Tariff for THR is cheaper than long-term conservative treatment for osteoarthritis of the hip.

There is over 16 fold variation in hip replacement rate per 1000 population by PCT across England.¹⁰

The outcome of THR is better when well tried (e.g. ODEP 10A rated implants¹¹) are used, particularly when performed by experienced surgeons (for example those doing more than 70 per annum¹²).

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Complex cases and younger patients with arthritis due to childhood hip disorders should be performed in centres performing high volumes of these cases.

This pathway is a guide which can be modified according to the needs of the local health economy.

1 High Value Care Pathway for pain arising from the hip in adults

1.1 Primary Care

Assessment:

- history - pain in the groin, medial thigh and greater trochanter radiating to thigh and knee at rest and/or after activity or isolated knee pain condition having an impact on occupation, daily activity and sports (e.g. decrease in walking distance, disability in negotiating stairs and performing pedicure)
- isolated pain over the greater trochanter settles in 64% of patients after one year and 71% after five years⁴
- examination - examine the hip for tenderness and irritability on movement.
- investigations: a plain A-P radiograph of the pelvis may be requested to confirm the diagnosis after history and examination
- no further imaging (e.g. MRI or bone scan) is appropriate before referral

Emergency referral to secondary care

- hip pain associated with systemic symptoms, signs of infection, known primary malignancy, severe muscle spasm, sudden inability to bear any weight, history of a fall¹³

Immediate referral to secondary care

- severe pain unresponsive to analgesia and persistent loss of function affecting employment

Management - offer to all people

Mild symptoms

- offer verbal and written information about condition⁹

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- offer information to achieve weight loss if people are overweight or obese as a core treatment⁹
- advise local muscle strengthening and general aerobic exercise as a core treatment⁹
- use shared decision making tools
- suggest oral simple analgesia and anti-inflammatory medication
- assess need for aids and devices (refer to occupational therapy or physiotherapy) including instruction in using a walking aid.
- prescribe supervised and evidence based physical therapies after assessment by an appropriate HCPC registered practitioner

Moderate symptoms:

- add NSAIDs or stronger analgesics
- in very elderly patients and those assessed to be unsuitable for surgery consider referral for image guided intra-articular steroids - beneficial for between 3 weeks and 3 months.¹⁴

Refer to intermediate or secondary care:¹⁵

- young adults (<40) with persistent hip pain which affects activities of daily living, work or leisure.
- all adults with painful irritable and stiff hip interfering with sleep, activities of daily living, work or leisure not controlled with measures above
- referral should be independent of the radiographic grade of arthritis.
- refer patients before there is prolonged and established functional limitation and severe pain⁹
- age, gender, smoking, obesity and co-morbidity should not be barriers to referral
- ensure that patients with significant co-morbidities [systemic or local] have appropriate investigations and treatment to optimise their condition before referral.
- patients who are considered not suitable for surgery by one of the surgical team should be referred for a complex care package

1.2 Intermediate Care¹

Intermediate care should form part of an integrated care programme with close links to primary and secondary care using protocols agreed with secondary care.

Assessment

- assessment as above
- re-assess for urgent referral to secondary care

¹ Those services that do not require the resources of a general hospital, but are beyond the scope of the traditional primary care team (René JFM, Marcel GMOR, Stuart GP, et al. What is intermediate care? BMJ 2004;**329**(7462):360-61.)

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Management

Non-operative interventions if not already offered

- use shared decision making and define treatment goals, taking into account personal circumstances e.g. occupation, level of activity/ sports

Provision of appropriate aids if not already used⁹

Specific goals based supervised and evidence based physiotherapy programme [for up to 6 weeks] if this has not already been carried out in primary care¹⁶

Referral to secondary care

- if persistent pain and disability has not responded to up to 12 weeks of evidence based non-surgical treatments¹⁶⁻¹⁸, this time to include any manual therapy (including physiotherapy) received in primary care.

1.3 Secondary Care

Assessment

- history and examination
- plain radiographs
- further imaging if indicated

Management

The decision to offer patients surgery is based on their symptom pattern, with the type of surgery determined by age¹⁹, diagnosed pathology and the patient's preference.

All patients must have engaged in shared decision making about alternatives. This includes presenting the patient with information on all treatment options, including surgery, and a clear description of the risks and benefits of each treatment.

The NHS Hip Arthroplasty Surgery Decision Making Tool can be used when arthroplasty is being considered.²⁰

Patients should be informed that the decision to have surgery can be a dynamic process and a decision to not undergo surgery does not exclude them from having surgery at a future time point.

Hip preserving operations

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Hip preserving operations include surgery for impingement and osteotomy for malalignment where there is the potential for developing early osteoarthritis. This surgery is best performed in centres undertaking high volumes of surgery on young adults' hips.

Total hip replacement

After appropriate diagnosis, consider **total hip replacement** when:²¹

- pain is inadequately controlled by medication
- there is restriction of function
- the quality of life is significantly compromised
- there is narrowing of the joint space on radiograph

Having established the need for surgical intervention the operation should be performed as early as possible²².

- There are important choices to be made on technique, implant and bearing surface, and these should be made on a case-by-case basis by the surgeon taking into account the most recent evidence from the NJR². Hip resurfacing may be appropriate in young active patients with suitable anatomy.²³
- Enhanced Recovery protocols should be followed in the perioperative period including an individual needs based assessment prior to discharge. Service managers should ensure that there are support services to allow enhanced recovery.

The need for a package of care, including the use of support services, must be assessed pre-operatively to avoid delayed discharge.

The orthogeriatrician can help manage very elderly patients, especially those with co-morbidity.

Follow up visits

Patients over 75 years at primary THR with ODEP 10A rated implants need not be routinely reviewed after the post-operative period.

² Ceramic bearings have certain theoretical advantages in terms of wear resistance and may be suitable for younger and more active patients. There may also be a place for ceramic femoral heads if larger diameter heads are used to minimise dislocation risk. This may protect the trunnion from potential corrosion risks, regardless of the counter face bearing. However Metal on polyethylene remains a very effective bearing and remains the most popular choice. Both cemented and uncemented fixation show excellent efficacy. Currently uncemented acetabular components are required for ceramic on ceramic bearings.

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ODEP 10A rated implants should be followed up in the first year, once at seven years and three yearly thereafter in asymptomatic patients. Telephone or web-based PROMS may be useful to monitor outcome.

Novel or modified implants²⁴ should be introduced conforming with the Beyond Compliance principles with increased follow-up - usually annually for the first five years, two yearly to ten and three yearly thereafter.

Routine follow up in General Practice is not advised.²⁵

Metal on Metal bearing hips should be followed up in accordance with existing advice from the MHRA. This is supported by the BHS and the BOA.

Secondary Care

Surgery for hip impingement may be considered where there is diagnosis of hip impingement and failure of non-operative management.^{26,27}

Femoral/pelvic osteotomy may be considered in:²⁸

- patients aged <50 years with persistent hip symptoms with abnormalities of femoral and/or acetabular anatomy

These operations should be carried out by surgeons with a declared specialist interest, and expertise, in young adult hip problems who should contribute data to the Non Arthroplasty Hip Register (<http://www.britishhipsociety.com/NAHR>).

An arthritic hip with severe acetabular bone loss, abnormal anatomy (such that non-standard implants may be necessary), prior fusion and cases secondary to infection should be considered specialised surgery and commissioned by NHS England.

Patients who have undergone previous hip surgery should normally be treated by surgeons with a recorded interest in complex and revision hip arthroplasty working in higher volume centres.

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2 Procedures explorer for pain arising from the hip in adults

Users can access further procedure information based on the data available in the quality dashboard to see how individual providers are performing against the indicators. This will enable CCGs to start a conversation with providers who appear to be 'outliers' from the indicators of quality that have been selected.

The Procedures Explorer Tool is available via the [Royal College of Surgeons](http://www.rcs.org) website.

Procedure	OPCS4 codes*	Exclusions
Primary total hip replacement with or without cement	W3712 W371 , W379 , W381 , W389, W391, W399, W931, W939, W941, W949, W951, W959	
Total prosthetic replacement of the hip, with or without cement, bilateral	All above codes with Z941 As in primary hip replacement with code Z941 for bilateral operations	
Complex primary total hip replacement (including bone grafting or femoral osteotomy)	W3713	
Hip resurfacing arthroplasty	W3715 W581 with Z843	
Hip resurfacing arthroplasty bilateral	W3719 W581 with Z843 and Z941	

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3 Quality dashboard for pain arising from the hip in adults

The quality dashboard provides an overview of activity commissioned by CCGs from the relevant pathways, and indicators of the quality of care provided by surgical units.

The quality dashboard is available via the [Royal College of Surgeons](http://www.rcs.org) website.

For current dashboard indicators (see appendix 1)

Measure	Definition	Data Source*
1. Standardised activity rate	Activity rate standardised for age and sex	HES/ Quality Dashboard appendix 1
2. Average Length of stay	Total spell duration/total number of patients discharged	HES/ Quality Dashboard appendix 1
3. Day case rate	Number of patients admitted and discharged on the same day/total number of patients discharged	HES/ Quality Dashboard appendix 1
4. Short stay rate	Number of patients admitted and discharged within 48 hours /total number of patients discharged	HES/ Quality Dashboard appendix 1
5. 7 /30 day readmission rate	Number of patients readmitted as an emergency within 7/30 days of discharge /total number of patients discharged	HES/ Quality Dashboard appendix 1
6. Reoperations within 30 days/1 year	Excludes Cancer, dementia, mental health Number of patients re-operated during an emergency readmission within 30 days/ 1 year /total number of patients discharged	HES/ Quality Dashboard appendix 1
7. In hospital mortality rate	Number of patients who die while in hospital /total number of patients discharged	HES/ Quality Dashboard appendix 1

Areas for development of dashboard

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Measure	Evidence Base	Data Source*
PROM (OHS) change at 6 months post-surgery for total hip replacement (THR) (and increased time periods as they become available)	National data set	The Health and Social Care Information Centre
Enhanced recovery programme for THR	HES data set	HES
Rate of blood transfusion in THR	BOA Guidance on Blood-transfusion in orthopaedic surgery	Trusts
Infection rate (THR)	HES data set	HES
Risk assessment for thromboprophylaxis with THR	NICE	Trusts
Implant dislocation rates		HES/ NJR
Use of cemented implants in patients over 70 years	% patients over 70 years having cemented implant Reduces rate of revision and cost	NJR, HES
Peri-prosthetic fractures²⁹	HES	HES/NJR
Rate of Revision		NJR
Proportion achieving Best Practice Tariff (2014)³		
Completion of minimum dataset for non arthroplasty surgical operations in Non Arthroplasty Hip Register (NAHR)	NAHR	NAHR, HES

* includes data from HES, National Clinical Audits, Registries

³ The proposed changes to the best practice tariff for 2014/15 were not confirmed at the time of finalising the documents.

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4 Levers for implementation

4.1 Audit and peer review measures

Levers for Implementation are tools for commissioners and providers to aid implementation of high value care pathways.

Measure	Standard	Data source
Adherence to NICE Guidance for referral	Percentage of people referred to secondary care for whom core treatments options attempted	Local use of referral checklist/tool Audit Peer review through GP
Patient Decision Aids	Number of patients confirming awareness / use of NHS Direct Patient Decision Aid	Quality Outcomes Framework QP indicators
Change in PROM score for THR	A centre should demonstrate improved PROM outcome	National PROMs data
Enhanced Recovery	Number of patients cared for along an Enhanced Recovery Care Pathway	Performance on National ER indicators
Use of British Hip Society follow up protocol	% using BHS Follow up protocol	Provider
Availability of MARS MRI imaging for metal-on-metal arthroplasty and specialist musculoskeletal radiologists	Statement confirming the provision	Provider

4.2 Quality Specification/CQUIN (Commissioning for Quality and Innovation)

Measure	Description	Data specification (if required)
Preoperative assessment clinic.	Reduces late cancellation	Provider
24 hour telephone availability of	Avoids inappropriate treatment	% > 24 hour delay in

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a member of the arthroplasty team	by community services, reduced late cancellation	treatment of complication
Routine follow up by Arthroplasty Care Practitioners and/or using telephone PROMs and community radiography to minimize trips to hospital	Improves follow up of patients at risk, frees time in outpatient clinics to assess new patients Makes follow up less of a burden to patients	% patients >75 years <65 years followed up in hospital clinic Alternative clinics
Target length of stay (LoS) should be 3-4 days	Encourages early supported discharge	% patients with LoS > 4 days
Proportion achieving Best Practice Tariff [2014]		
Percentage of patients entered onto NJR	Improves data quality	>90%

5 Directory

5.1 Patient Information for pain arising from the hip in adults

Name	Publisher	Link
Hip replacement	NHS Choices	www.nhschoices.nhs.uk
Hip joint replacements	EMIS	www.patient.co.uk
Hip OA decision aid	Right Care	http://sdm.rightcare.nhs.uk/pda/osteoarthritis-of-the-hip
NHS Evidence	NHS	www.evidence.nhs.uk/
NICE OA Guideline		http://guidance.nice.org.uk/CG/Wave0/685

5.2 Clinician information for pain arising from the hip in adults

Name	Publisher	Link
Hip disease	NICE	www.nice.org.uk

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replacement
prostheses

Hip osteoarthritis NHS Clinical Knowledge
Summaries www.cks.nhs.uk

Hip pain Map of Medicine healthguides.mapofmedicine.com

6 Benefits and risks

Benefits and risks of commissioning the pathway are described below.

Consideration	Benefit	Risk
Patient outcome	Ensure prompt access to effective treatments so that patients can regain their independence and return to work	Prolonged treatment with patients who are disabled and dependent, unable to work if of working age
Patient safety	Reduce chance of missing serious hip pathology or prolonging disability	
Patient experience	Improve access to patient information, support groups	Patients not taking charge of their care, dependence on Primary and Secondary care
Equity of access	Improve access to effective procedures	With-holding of access for financial reasons alone
	Reduce unnecessary referral and intervention	Resource required to establish community specialist provider

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7 Further information

7.1 Research recommendations

- Evaluation of symptoms scoring systems to guide referral and management (NIHR HTA call)
- Effectiveness of non-surgical treatments
- Effectiveness of assessment and management in primary care
- Effectiveness of non-replacement surgery for the arthritic hip

7.2 Other recommendations

1. Improved patient information
2. Clinician education
3. Mandatory data collection
4. Separation of co-morbidity from complication from IC CC list
5. Development of a relevant and comprehensible undergraduate musculoskeletal curriculum that prepares students for primary care

7.3 Evidence base

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7.4 Guide development group for pain arising from the hip in adults

A commissioning guide development group was established to review and advise on the content of the commissioning guide. This group met four times, with additional interaction taking place via email.

Name	Job Title/Role	Affiliation
Gordon Bannister (Chair)	BHS, Consultant Orthopaedic Surgeon	BHS, BOA
Joe Dias	Chair, Musculoskeletal Commissioning Guidance Development Project; Consultant Orthopaedic Surgeon	BOA
Martyn Porter	BOA, Consultant Hip Surgeon	BHS, BOA
John Timperley	BHS, Consultant Hip Surgeon	BHS, BOA
Paul Creamer	Consultant Rheumatologist	
Karl Stainer	General Practitioner	
Alison Smeatham	Extended Scope Practitioner (Physiotherapy)	
John Collins	Patient Representative, and former lay member of the research ethics committee	
Steve Lloyd	Commissioner	Chair of Hardwick CCG in Derbyshire
Bob Smith	Patient Representative	BOA PLG

Information specialist support provided by Bazian, 10 Fitzroy Square, London, W1T 5HP.

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7.5 Funding statement

The development of this commissioning guidance has been funded by the following sources:

- DH Right Care funded the costs of the guide development group, literature searches and contributed towards administrative costs.
- The Royal College of Surgeons of England (RCS Eng) and the British Orthopaedic Association (BOA) provided staff to support the guideline development and performed the quality assurance

7.6 Methods Statement

The development of this guidance has followed a defined, NICE Accredited process. This included a systematic literature review, public consultation and the development of a Guidance Development Group which included those involved in commissioning, delivering, supporting and receiving surgical care as well as those who had undergone treatment. An essential component of the process was to ensure that the guidance was subject to peer review by senior clinicians, commissioners and patient representatives.

Details are available at this site:

www.rcseng.ac.uk/providers-commissioners/docs/rcseng-ssa-commissioning-guidance-process-manual/at_download/file

7.7 Conflict of Interest Statement

Individuals involved in the development and formal peer review of commissioning guides are asked to complete a conflict of interest declaration. It is noted that declaring a conflict of interest does not imply that the individual has been influenced by his or her secondary interest, but this is intended to make interests (financial or otherwise) more transparent and to allow others to have knowledge of the interest. Professor Joe Dias (Chair, Musculoskeletal Commissioning Guidance Development Project; Consultant Orthopaedic Surgeon) has seen and approved these. All records are kept on file, and are available on request.

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Appendix 1: Dashboard

To support the commissioning guides the Quality Dashboards show information derived from Hospital Episode Statistics (HES) data. These dashboards show indicators for activity commissioned by CCGs across the relevant surgical pathways and provide an indication of the quality of care provided to patients.

The dashboards are supported by a metadata document to show how each indicator was derived.

<http://rcs.methods.co.uk/dashboards.html>

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Created and maintained by Methods Insight Analytics in association with BOA
Rightcare Surgical Commissioning Dashboard: Orthopaedics

The Right Care Dashboard provides rates of Activity for CCGs for interventions identified as a priority by the surgical specialist association. These rates are directly standardised against the national population for Age and Sex. This dashboard supports the Painful Osteoarthritis of the Hip commissioning guidance document developed by the BOA working group with the RCSE.

Report Overview

Intervention Name	Indicator name*	Period	Value	National Mean	Chart	Trend
Hip resurfacing	Activity rate per 100,000 population (DSR)	RY Q3 1213	0.36	3.97	[Chart]	[Trend]
	Average Length of Stay (Days)	RY Q3 1213	3.00	3.44	[Chart]	[Trend]
	7 Day Re-admission rate (%)	RY Q3 1213	0.00%	0.00%	[Chart]	[Trend]
	30 Day Re-admission rate (%)	RY Q3 1213	0.00%	0.20%	[Chart]	[Trend]
	Re-operations within 30 Days (%)	RY Q3 1213	0.00%	0.40%	[Chart]	[Trend]
	Day case rate (%)	RY Q3 1213	0.00%	0.59%	[Chart]	[Trend]
	In Hospital Mortality Rate (per 1,000 provider spells)	RY Q3 1213	0.00	0.00	[Chart]	[Trend]

How to interpret charts

If a CCG is in this range their rate is much worse than expected by chance (99.8% or 3SD)**

If a CCG is in this range their rate is worse than expected by chance (2SD or 95%)**

If a CCG is in this range their rate is better than expected by chance (2SD or 95%)**

If a CCG is in this range their rate is much better than expected by chance (99.8% or 3SD)**

This diamond represents the value for the CCG.

The vertical bar represents the average value for all CCG in England

The scale of each chart is dynamic to show a range that enables each measure to be viewed clearly for the CCG in question. See Meta data document * for further information.

The chart on the left shows a CCG whose performance on this indicator is better than the national picture by a degree that is unlikely to be explained by random chance**

The two charts on the left shows a CCG whose performance on this indicator does not differ from the national picture by more than can be explained by random chance**

The chart on the left shows a CCG whose performance on this indicator is worse than the national picture by a degree that is unlikely to be explained by random chance**

The chart on the left is for an indicator that does not have a desired direction for improvement. The CCG shown in this example is within the expected range based on the national picture.

* For a full description of each metric and metadata, please see technical guidance.

** These charts are constructed using statistical process control (SPC) principles and use control limits to indicate variation from the national mean. The display shows both two standard deviation (95%) control limits and three standard deviation (99.8%) control limits. Values within these limits (the light grey section) are said to display 'normal cause variation' in that variation from the mean can be considered to be random. Values outside these limits (in the light green or orange sections) are said to display 'special cause variation' at a two standard deviation level, and a cause other than random chance should be considered. Values outside these sections (in the dark green or red sections) also display 'special cause variation' but against a more stringent test.

Variation at the two standard deviation level can be considered to raise an alert, and variation at the three standard deviation level to raise an alarm.

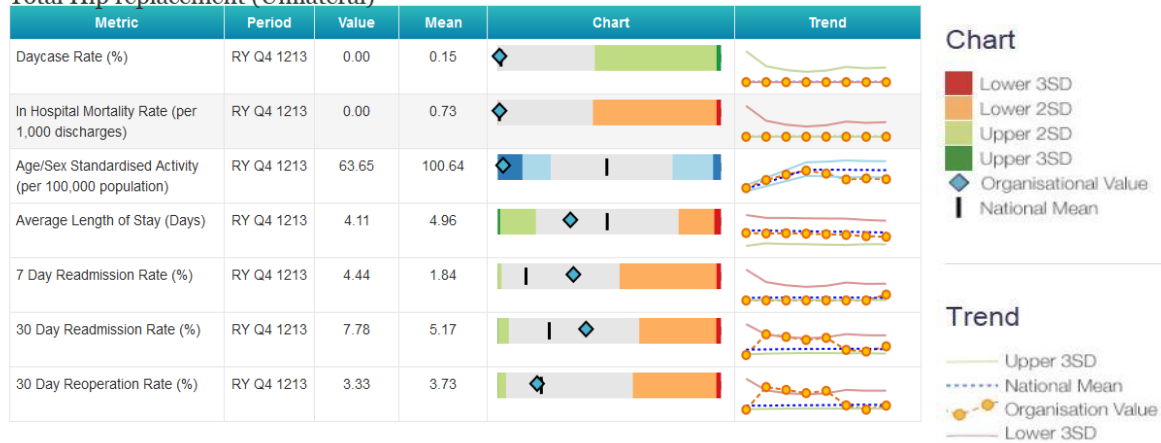
Commissioning guide 2013

Pain arising from the hip in adults

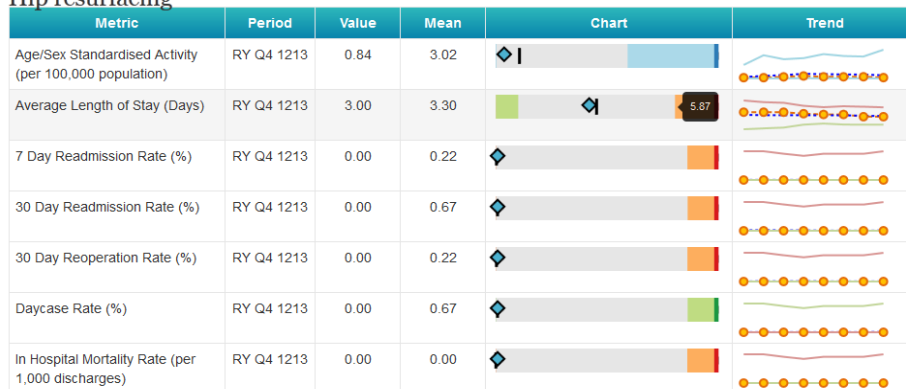
Example CCG

Orthopaedics-Painful Osteoarthritis of the Hip

Total Hip replacement (Unilateral)




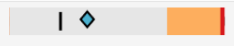
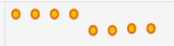

Hip resurfacing



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Pain arising from the hip in adults

Total Hip replacement (Bilateral)

Metric	Period	Value	Mean	Chart	Trend
Age/Sex Standardised Activity (per 100,000 population)	RY Q4 1213	1.54	1.29		
Average Length of Stay (Days)	RY Q4 1213	12.50	8.39		
7 Day Readmission Rate (%)	RY Q4 1213	0.00	0.30		
30 Day Readmission Rate (%)	RY Q4 1213	0.00	0.90		
30 Day Reoperation Rate (%)	RY Q4 1213	0.00	0.30		
Daycase Rate (%)	RY Q4 1213	0.00	0.30		
In Hospital Mortality Rate (per 1,000 discharges)	RY Q4 1213	0.00	12.01	