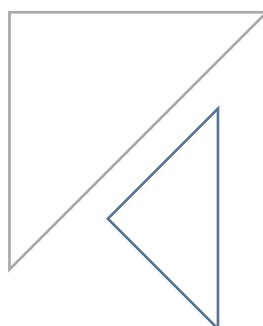


10TH ANNUAL REPORT 2025



**Non-Arthroplasty
Hip Registry**



Smith+Nephew



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CHAIRMAN'S FOREWORD

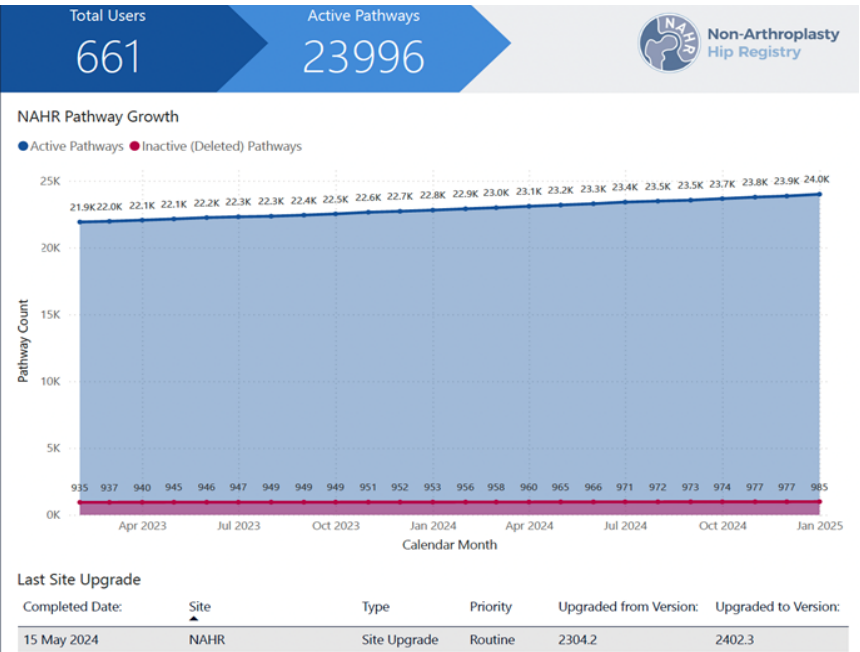
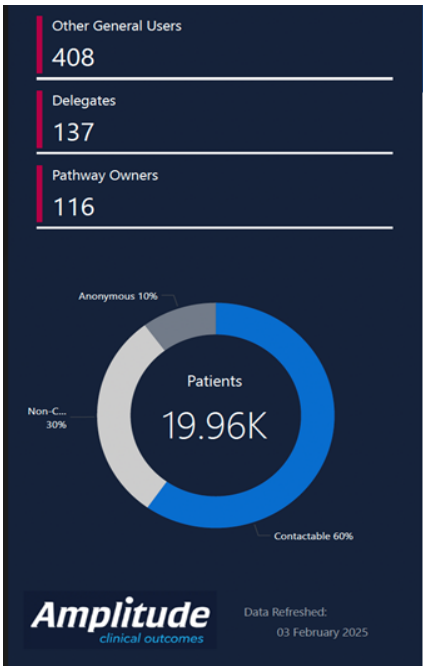


Tony Andrade

Chairman, Non-Arthroplasty Hip Registry

It is a pleasure and an honour to present the 10th Annual Report from the UK Non-Arthroplasty Hip Registry (NAHR).

The registry now has almost **24,000 active pathways** and even though the number of surgeons contributing to the registry does seem to have fallen, logistical challenges with data submission continue to be a problem for many UK surgeons. The NAHR board with the support of the regional representatives will continue to work hard to overcome these challenges and increase the data capture of all hip preservation procedures.



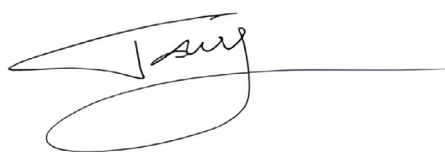
10th Annual Report – I am indebted to Justin Green, Matthew Horner, Callum McBryde and Ajay Malviya for their hard work in producing this report. The association between increased BMI and poorer outcomes is again identified in this year's report and should serve to help counsel patients prior to surgery.

The NAHR regional representatives – will have a very important role in the coming year engaging with surgeons in their region to encourage them to contribute data to the registry. This continues to be a priority for the NAHR, particularly as the promise of mandating data submission from **MDOR** has not materialised, and the wheels of NHS England seem to be turning very slowly with the outcomes and registries programme.

The NAHR board / User Group – This group of dedicated individuals continues to tirelessly work on supporting and evolving the registry. I would add thanks to Ajay Malviya, Vikas Khanduja, Marcus Bankes, Tim Board and Callum McBryde for their ongoing work. If there are any surgeons who are already contributing to the registry who would like to join the board, please do contact us.

Sponsors – I would like to thank Smith and Nephew who have supported the registry from inception and continue to do so. I would also like to thank NTL Biologica who have renewed their support of the registry.

Lastly, and most importantly, on behalf of the **NAHR board**, I would once more like to thank all patients and surgeons who, have in the past, and will in the future contribute to the registry. Your commitment to share your data is what fuels the NAHR's success, and we welcome any feedback you might have on how we can shape it for the future.



Tony Andrade
Chairman, Non-Arthroplasty Hip Registry

NAHR BOARD

CURRENT BOARD MEMBERS



Tony Andrade
Chair

Mr Tony Andrade is a fellowship trained consultant Orthopaedic, Hip and Knee surgeon with a special interest in Hip preservation and arthroscopic hip surgery.

He established the hip preservation service at the Royal Berkshire Hospital in 2002 which rapidly evolved into a tertiary referral centre. A pioneer in surgical techniques, he launched a visiting surgeon program to share expertise globally and founded a hip arthroscopy fellowship program in 2016. He has also been fellowship director for a lower limb arthroplasty fellowship at the Royal Berkshire Hospital since 2004, and in that same year co-founded the Combined Orthopaedic and Medical Microbiology Service (COMMS) to advance orthopaedic infection treatment.

He has published extensively, contributed to consensus statements, and co-authored a landmark BMJ study on arthroscopic hip surgery for femoroacetabular impingement. His research has received prestigious awards from EFORT and ESSKA.

He has been a member of the International Society for Hip Arthroscopy (ISHA) since it was founded in 2008, he hosted the 2015 Annual Scientific Meeting in Cambridge and was the 2020-21 president, of what is now known as ISHA – The Hip Preservation Society.

As chair of the Non-Arthroplasty Hip Registry (NAHR) for the British Hip Society, Mr Andrade supports national data collection on all of hip preservation.



Ajay Malviya
Past Chair

Mr Ajay Malviya is a Consultant Orthopaedic Surgeon at Northumbria Healthcare NHS Foundation Trust. He trained in the Northern Deanery and has done specialist fellowships in hip preservation and joint replacement surgery in Cambridge, London and Switzerland.

He specialises in hip arthroscopy for femoroacetabular impingement, trochanteric pain syndrome and periacetabular osteotomy for hip dysplasia using a minimally invasive approach. He deals with sports injuries of the hip and has published and presented widely on the results of hip arthroscopy in athletes and general population. He has completed a PhD on the role of hip arthroscopy in femoroacetabular impingement.

He was awarded the prestigious ABC (America-Britain-Canada) fellowship in 2016 by the British Orthopaedic Association that involved visits to various high-profile centres in USA and Canada learning about new systems and techniques.

He is a very active researcher with more than 100 peer-reviewed publications in esteemed journals. He is a Trustee of the British Orthopaedic Association and the Vice-Chair of BOA Education and Careers committee. He is an examiner for the Royal College of Surgeons (FRCS T&O).



Vikas Khanduja

Vikas Khanduja is a Consultant Orthopaedic Surgeon specialising in hip surgery and has a particular interest in arthroscopic surgery of the hip. He has been instrumental in setting up & developing the tertiary referral service for Young Adults with Hip Pathology in Cambridge for East of England.

Complementing his clinical practice, his research interests centre around disease stratification of FAI using novel imaging techniques, better pre-operative planning tools using dynamic analysis and optimisation of arthroscopic management of FAI via precision surgery to improve outcomes.

Along with a busy clinical practice, he also chairs a vibrant and productive research group, Cambridge Young Adult Hip Research Group, the main focus of the group being improving outcomes for young adults with hip pathology. He has authored over 200 peer reviewed articles (Pubmed) and three books.

Vikas is the recipient of the Hunterian Professor Award by the Royal College of Surgeons in England, the American and British Hip Society Travelling Fellowship in 2011, the Arnott Medal presented by the Royal College of Surgeons of England in 2013 and the Insall Fellowship presented by the American Knee Society and Insall Foundation in 2014.

Vikas sits on the Board of Directors for SICOT as the President, the British Hip Society as the Past President, ESSKA-EHPA as the Founder Chair and is on the Board of ISHA and BOA. He is also the Associate Editor in Chief to JISAKOS and the past Chair & current Trustee to the Non Arthroplasty Hip Registry (NAHR).



Marcus Bankes

Mr Marcus Bankes was a senior surgeon on the Hip Unit at Guy's and St Thomas' Foundation NHS Trust and was appointed Consultant Orthopaedic Surgeon in 2002.

He is now in full time private practice. His practice consists almost exclusively of the surgical treatment of young adult hip disorders, including arthroscopic and open hip preservation techniques and arthroplasty, particularly with ceramic-on-ceramic bearings. Recognised as an opinion leader in hip surgery, Marcus is a regular speaker at national meetings and ISHA (The Hip Preservation Society) as well as being a reviewer for a number of orthopaedic journals.

He pioneered the use of the British Non-Arthroplasty Hip Registry (NAHR) and was the first Chair of its User Group. He remains on the User Group of the NAHR and has recently led on the Minimum Data Set 2.0 project. His interests outside work include film, TV, pop music, Apple electronic goods, and most sport, particularly cycling.



Callum McBryde

Mr. Callum McBryde is a Consultant Orthopaedic Surgeon based in Birmingham, UK, specialising in hip and groin conditions, particularly in young and active patients. He was appointed as a consultant to Royal Orthopaedic Hospital in 2011 where he has gone on to help develop a leading centre for young adult hip surgery with his colleagues including a strong fellowship program.

After earning his medical degree from the University of Manchester in 1998, Mr. McBryde completed his general surgical and specialist orthopaedic training in Birmingham. Early in his career, he was honored with the RH Sage Award for the best surgical trainee of the year. His involvement in hip resurfacing research led to the first-ever McMinn scholarship from the British Hip Society, culminating in a doctoral degree from the University of Birmingham.

Mr. McBryde completed a hip surgical fellowship in Sydney under Dr. Solomon and the European Travelling Fellowship from the British Hip Society, training with a number of renowned surgeons in Switzerland. His surgical proficiencies encompass hip arthroscopy, periacetabular and triple pelvic osteotomies, hip resurfacing and complex primary total hip replacements. Beyond his clinical practice, he contributes to the field as a member of the editorial board of the Bone and Joint Journal, serves on the Non-Arthroplasty Hip Register board, and is the Chairman and trustee for the Birmingham Orthopaedic Charity .

He has published extensively in a number of peer reviewed journals on hip surgery and is regularly invited internationally to lecture and teach.



Tom Pollard

Mr Tom Pollard is a Consultant Orthopaedic Surgeon specialising in hip surgery with a particular interest in young adult hip conditions.

The majority of his training in hip arthroscopy was with Tony Andrade, and he joined him as a Consultant colleague at the Royal Berkshire Hospital, Reading, in 2012. Since starting Consultant practice, he has consistently performed approximately 250 hip arthroscopies annually, making him one of the UK's highest volume and most experienced hip arthroscopy surgeons.

Prior to starting Consultant practice, Tom completed an MD entitled 'The aetiology of early osteoarthritis of the hip'. He was awarded the International Society for Hip Arthroscopy's top research prize at the New York and Paris meetings.

He has expanded the understanding of how hips fail in young adults and how they should be studied and treated by authoring many articles in the field of young adult hip surgery. His research has also included studies related to simulator training in hip arthroscopy, and he was a coauthor on the FAIT project, collaborating with colleagues in Oxford and elsewhere.

Tom's NHS practice remains at the Royal Berkshire Hospital and he works privately at Fortius Clinic London and Circle Reading. The Reading Hip Arthroscopy fellowship has been running since 2015 and he is a keen participant in the Smith & Nephew sponsored visiting surgeon programme.



Colin Holton

Colin is a Consultant Orthopaedic Surgeon based in Leeds since 2014, specialising in hip and paediatric orthopaedic surgery. He has an NHS and private practice. Colin is a Clinical Director at Leeds Children's Hospital for over 1,400 staff and is an Honorary Clinical Lecturer at the University of Leeds.

Colin specialises in hip arthroscopy, hip replacement, and peri-acetabular (PAO) and femoral osteotomies, with a particular focus on adolescent and young adult hip conditions. He has completed fellowships in the UK and Denmark and continues to be actively involved in clinical research, serving as Principal Investigator on several NIHR studies.

He has recently joined the NAHR board after serving as a regional representative for several years. Colin is excited to continue to develop and improve the impact the NAHR team can have here in the UK and world.



Jonathan Hutt

Mr Jonathan Hutt is a consultant orthopaedic surgeon who specialises in all aspects of hip surgery from adolescence onwards, performing a complete range of both hip preservation and arthroplasty surgery with a particular interest in the treatment of young and active patients.

Following undergraduate training in Oxford and London, he completed his orthopaedic training in the South West Deanery which was followed by two fellowships in Montreal, Canada and Guy's Hospital in London.

Having started his consultant career at St. George's Hospital, he later moved to UCLH where he now leads one of the largest and busiest hip preservation units in the UK, in addition to running a fellowship programme and regularly hosting visiting surgeons from the UK and worldwide.

In 2022, he was awarded the distinguished Rothman-Ranawat travelling fellowship by the American Hip Society.

He is an active member of numerous hip societies has published extensively on hip conditions, and is an honorary associate professor at UCL.

RETIRED BOARD MEMBER



Tim Board

Professor Tim Board was a founding member of the NAHR user group and has been pivotal to the evolution of the registry over the last 13 years.

He leaves the NAHR board this year as he takes on the challenges of being on the presidential line for the British Hip Society.

We thank him for his tireless efforts on the board and wish him well with his new role.

CONTRIBUTORS TO NAHR REPORT



Justin Green

NAHR Fellow

Justin is an Orthopaedic Registrar at Northumbria Healthcare Trust who is involved in clinical informatics and AI innovation within the NHS. He was awarded the combined Orthopaedic Research UK and British Hip Society Fellowship in 2022 to explore the use of AI in determining long-term outcomes following hip preservation surgery with the NAHR, forming an integral part of his current Ph.D. in Artificial Intelligence, at Newcastle University School of Computer Science. His approach to using AI in healthcare has been recognised internationally by both industry and the orthopaedic community for his work in developing robust and responsible clinical decision support, leveraging AI and machine learning technology safely. He received an award for his work at ISHA, Cape Town in 2023.

Justin acts as the Clinical Data Scientist and AI Technology Lead within Northumbria NHS trust and a member of the NorthHFutures Digital skills and Training board where he continues to develop and promote digital training for clinical staff across the North East, in addition to being an active participating in the regional NHS Education England Faculty of Digital Health steering group where he has established the North East Trainee Clinical Informatics Forum in order to support postgraduate doctors in developing digital skills.



Matthew Horner

Young Adult Hip Fellow

Matt completed orthopaedic specialist training on the Welsh rotation obtaining CCT in August 2024. Matt has a particular interest in paediatric and adult hip surgery, both preservation and arthroplasty. Having completed a paediatric fellowship in Cardiff, he is currently undertaking a 12-month young adult hip fellowship at the Royal Orthopaedic Hospital, Birmingham under the supervision of Callum McBryde, Angelos Politis and Peter Wall.

HISTORY OF THE NAHR

The creation of a NAHR was initiated by Professor John Timperley, Consultant Orthopaedic Surgeon at the Princess Elizabeth Orthopaedic Centre in Exeter and former President of the BHS. He identified the rise in hip preservation surgery but noted, in contrast to joint replacement surgery, a lack of outcomes data outside of small scale published series. Given his interest and expertise in joint replacement registries from around the world, setting up a registry for non-hip replacement hip surgery seemed a logical thing to do. The motion to set up such a registry was unanimously supported by the Membership of the BHS at the Annual General Meeting in Torquay in March 2011 and the membership agreed that the BHS should fund the registry. The Registry went live in March at the 2012 BHS Annual Meeting in Manchester and was formally launched at the BOA Annual Congress in September 2012. NICE (National Institute for Clinical Excellence as it was then known) Interventional Procedure Guidance on Arthroscopic (IPG408) and Open (IPG403) Femoroacetabular Surgery for Hip Impingement Syndrome, published in September and July 2011 respectively, noted that clinicians should submit details to this national registry.

The User Group, initially chaired by Professor John Timperley and then Mr Marcus Bankes, developed during 2012 and 2013 and consisted of Mr Tony Andrade, Professor Tim Board, Professor Max Fehily, Mr Paul Gaston, and Mr Matt Wilson, with assistance from Mr Johan Witt and Professor Damian Griffin. A major streamlining exercise was undertaken in 2013 to improve surgeon compliance following meetings of interested parties at the BHS in Bristol in March and of the original NAHR User group at the BOA Congress in October. Whilst many arthroscopic and hip preservation surgeons were enthusiastic about the development of the NAHR in principle, many already had their own databases and were unsurprisingly unwilling to duplicate data entry.

It was therefore decided that use of the data collection infrastructure which already existed for the NJR in every hospital in England and Wales was essential for success to minimise surgeon involvement in data collection and capture cases.

In addition, a Minimum Data Set (MDS Version 1.0) was defined which included a pre-operative specific and general health measures, namely the iHOT-12 (International hip outcome tool - 12 question version) and the EQ-5D-5L (five-dimensional measure of health-related quality of life, five level questionnaire developed by the EuroQol Group) respectively. Standardised paper data collection forms were redesigned to have a similar appearance to NJR forms to help with this process. Whilst it may seem outdated to develop a paper-based system, availability of convenient hardware, particularly in clinic and theatre environments, varies immensely between hospitals. Post-operative outcome data is electronic however, and patients are currently invited to complete outcome questionnaires at six, twelve and twenty-four months after their operation with an email, linking them directly to the online forms.

Growth of the Registry continued and the MDS Version 1.1 was launched in February 2015 to include data fields for the extent of pre-existing articular cartilage damage on both sides of the joint. Whilst there was little change in the way data was collected, there was increasing interest in non-joint replacement registries from other specialties from the BOA, led at that time by the then President Colin Howie. This led to the formation of an umbrella organisation for these registries called TORUS in 2016 of which the NAHR was an original member. The formation of TORUS provided a shared operating framework that allowed consistency of practice and a central support function (to deal with issues such as data governance, contracting and managing registry suppliers, and resolving day-to-day issues) to reduce the burden on individual registries and introducing efficiencies.

The importance of the NAHR being part of TORUS has been particularly highlighted recently in view of the introduction of GDPR. Full release of MDS Version 2.0 along with the updated GDPR complaint consent form was therefore launched and has been in use. Elements of the enhanced dataset included: labral grafting and details of the graft length and material; number and type of labral anchors used, details of extra-articular procedures and there has been a further refinement of pelvic osteotomy types recorded.

The form has undergone further developments and the MDS Version 3.0 is now available for use and will collect more information on capsular management, thromboprophylaxis, heterotopic ossification medication and adhesion prevention. It will also be recording data on articular cartilage repair techniques and intra-articular adjuncts reflecting the ever-developing field of hip preservation. Clinicians can use the NAHR to collect and display comprehensive outcome data on all their patients using various outcome measures. The information sheet, consent form and minimum dataset version 3.0, which can be downloaded [here](#), are designed to reflect the familiar format of the NJR forms. They contain a basic mandatory dataset as well as an enhanced dataset for surgeons to record additional surgical findings.

The board and the leadership have altered over time and currently consists of six surgeons from across the country who dedicate a significant proportion of their time to the Registry. They lead by example, not just by contributing patients but also by ensuring updates, improving the quality of data analyses, working on the surgeon and patient compliance, maintaining finances, website development and annual reports.

At each Annual General Meeting of the BHS, an update of the NAHR is presented and a workshop arranged to encourage surgeons to join and submit data to the NAHR. This, the 10th Annual Report, provides a summary of the data available and can be used to guide further development of the registry.



NAHR ANNUAL REPORT



INTRODUCTION

We are very pleased to present the 10th Annual Report of the NAHR. Well over a decade since its introduction, the NAHR remains an invaluable asset for surgeons globally involved in hip preservation surgery. It is the largest non-arthroplasty hip registry in the world, consistently growing year by year. As of January 2025, we can report on 14,416 complete pathways and in the past twelve months alone, 847 procedures have been recorded by surgeons across a range of institutions. The minimum data set (MDS 3.0) introduced in 2021 marked a significant milestone in the report accounting for revision procedures allowing an accurate assessment of the results of these. Similarly to previous reports, all pathways with missing operative data have been excluded from the 2025 report allowing for more accurate in-depth analysis.

For the first time since the pandemic there has been a halt in the year-on-year reductions in the number pathways recorded in the NAHR, although the volume of procedures continues to be significantly lower than pre COVID levels. The reasons for this trend remain unclear with the possibility of more patients proceeding to arthroplasty as opposed to hip preservation. Interestingly, this year's report highlights a significant increase in the proportion of NHS funded hip preservation procedures in keeping with the ongoing recovery of healthcare services. We anticipate that pathways will likely eventually increase to pre-pandemic levels though this may take many more years based on recent data. This year we can provide information on funding sources for recorded NAHR procedures throughout the UK highlighting regional differences in the settings hip preservation surgery is being performed across the country.

This report highlights the substantial enhancements in patient-reported outcomes facilitated by NAHR-contributing surgeons, with evidence of markedly improved symptoms and quality of life. However, the voluntary nature of surgeon data submission to the NAHR remains an on-going hurdle. In 2024 the number of surgeons submitting pathways to the registry continued to decline despite the modest increase in the number of recorded procedures. We still await the implementation of recommendations from the Cumberlege report to mandate data submission for surgeons performing hip preservation.

Patient engagement and compliance with follow-up and outcome data collection, as with all registries poses another ongoing challenge. Mandating pre -and post- operative data collection would vastly optimise the use of the NAHR, allow robust assessment of outcomes and improve the evidence base of hip preservation procedures. Previous work by Mark Sohatee and colleagues has shown that registry-based RCTs are feasible with additional administrative support for enhanced follow up. This continues to highlight the importance of ongoing engagement with data submission to the NAHR to maximise the benefits of this invaluable resource.

AIM OF NAHR

The NAHR is open to data submission by members and non-members of the BHS. The aim is to benefit both patients and surgeons by collecting longitudinal data on patients undergoing an elective surgical procedure for hip pathology excluding patients who are having an arthroplasty or who have had an arthroplasty operation. Relevant operations include: arthroscopic and open surgery for FAI; PAO; reverse PAO for retroversion, femoral osteotomy; surgery for slipped capital femoral epiphysis (SCFE); surgery for developmental dysplasia of the hip (DDH); and other treatments for extra-articular hip problems such as trochanteric bursitis, abductor tears and external snapping of the hip. In essence any hip operation other than arthroplasty and acute fracture treatment is suitable for being recorded on the NAHR. It is quite likely that healthcare institutions, both private and within the NHS will soon require proof that outcome data is being collected. In addition, the collection of outcome data and reflection on the results is also considered an important component of the appraisal and revalidation cycle.

The NAHR data can be used to bring direct benefits to patients by:

- Improving patient awareness of the outcomes of operations on the hip, as results are available in the public domain.
- Comparing the success rates of different operations and surgical approaches to the hip.
- Helping to identify whether they would benefit from a specific surgical technique.
- Identifying which surgical procedure is most likely to bring benefit for a specific diagnosis.

The NAHR data and the annual report bring additional long-term benefits to surgeons and hospitals by:

- Providing feedback to orthopaedic surgeons to define which patients will benefit from surgery and what details of the operative procedure will define a good result; validated outcome data will be available to the surgeon
- Identifying which patients are likely to benefit from a particular procedure
- Promoting open publication of outcomes following surgery
- Comparison of patient reported outcomes for an individual surgeon with the national average and this document forming part the appraisal process
- Potentially linking to Hospital Episode Statistics (HES) and NJR data to enable follow-up into arthroplasty and accurately follow the lifespan of a patient's hip joint.

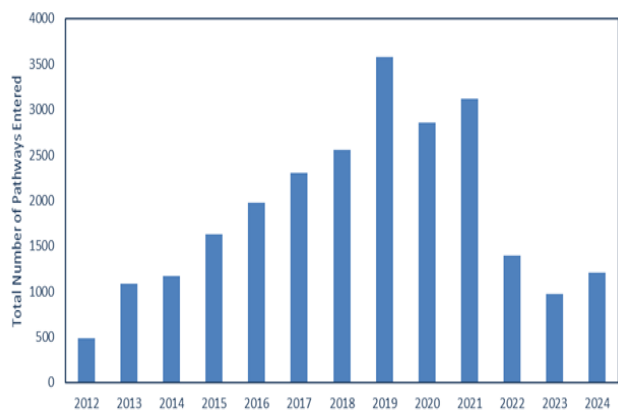
OVERVIEW OF THE DATA

PATHWAYS PER YEAR

A pathway on the NAHR is created when a patient’s details are entered for a non-arthroplasty procedure. The patient should have already completed their relevant pre-operative scores. The demographic data and in particular unique identifiers such as the NHS number allow for different treatments, potentially in different centres and by different surgeons, that follow the ‘journey’ of that hip through one or multiple hip preservation operations. The inclusion of an NHS number potentially allows linkage of the NAHR pathway with other registries such as the NJR. Therefore, it is highly desirable that this number is included for all patients.

Up until the 2022 annual report, we included pathways with missing operative data (these pathways have always been included within the denominator when reporting numbers). Pathways with missing operative data were particularly prevalent during 2020 and therefore the NAHR user group decided to exclude all pathways with missing operative data from the analysis, beginning from 2021 and including 2022. This was also applied retrospectively to the registry, hence the apparent change in pathways for previous years compared to earlier annual reports (Figure 1).

Figure 1: Total Number of Pathways uploaded per year



Between January 2012 and December 2024, a total of 14,416 pathways have been entered in the registry where operative data was completely recorded as per our inclusion criteria for the report. As illustrated in Figure 1 the 847 procedures recorded in 2024 remains well below peak pre-pandemic levels. There is however a slight increase in procedure volume compared to the previous 12months.

Unfortunately, despite the previously steady increase in the proportion of pathways meeting the criteria for inclusion, 2024 showed a rise in the number of pathways excluded for incomplete data (Figure 2)

Total pathways	Number of Pathways	Included	Excluded*
2012	485	400	85
2013	1085	488	597
2014	1169	993	176
2015	1624	1349	275
2016	1974	1648	326
2017	2305	1503	802
2018	2558	1678	880
2019	3581	1780	1801
2020	2858	988	1870
2021	3120	880	2240
2022	1389	878	511
2023	970	806	164
2024	1209	847	362

Figure 2: Percentage of pathways uploaded per year

Figure 3 shows the number of pathways by surgical approach. Arthroscopic surgery continues to make up the majority of procedures included in the registry. The exclusion of pathways with incomplete data has significantly reduced the number of cases where the approach was not recorded.

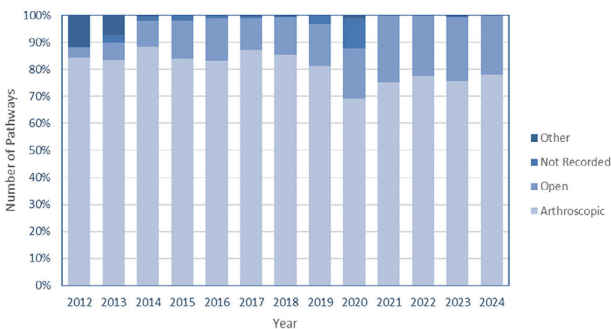


Figure 3: Pathways per year by surgical approach

NUMBER OF SURGEONS USING NAHR

In keeping with previous recent reports, the number of surgeons contributing data to the NAHR continues to decrease. Figure 4 shows the number of unique surgeons entering pathways per year since 2012, with a steady increase to a peak in 2018 with a subsequent persistent fall to 34 surgeons in 2024. This decline in the number of individual surgeons submitting data may highlight an encouraging centralisation of expertise in hip preservation surgery. The registry demonstrates that the majority of procedures have been performed by a relatively small number of high-volume surgeons. Nevertheless, whereas the NJR for example has a good mechanism for understanding the denominator of surgeons performing joint arthroplasty, there is no similar surrogate in hip preservation surgery. It is therefore it is equally possible that this drop in surgeons reflects a lack of data submission to the NAHR. It is vital that hip preservation surgeons are encouraged to contribute data to the registry, in light of the Cumberlege report and to allow an accurate assessment of non-arthroplasty hip surgery being undertaken in the UK.

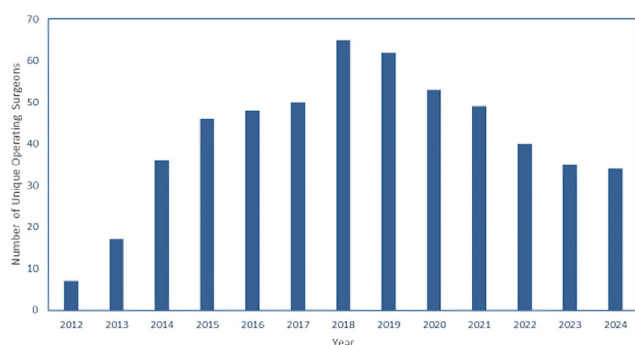


Figure 4: Surgeons contributing data to the NAHR

SURGEON PROCEDURES AND CASE VOLUME

The median number of procedures performed per pathway owner remains at 35. Figures 5 & 6 demonstrate the heterogeneity in case volume of surgeons using the NAHR. It remains the case that a small number of high-volume surgeons account for over 50% of cases recorded in the registry. One of the reasons for differing surgeon engagement with the registry is perhaps the difference in attitudes amongst surgeons, with some seeing the potential benefits to their own

practices and patients in the follow-up of outcome data.

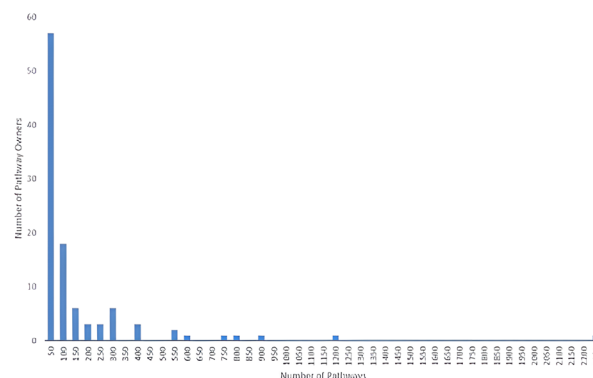


Figure 5: Number of cases per surgeon

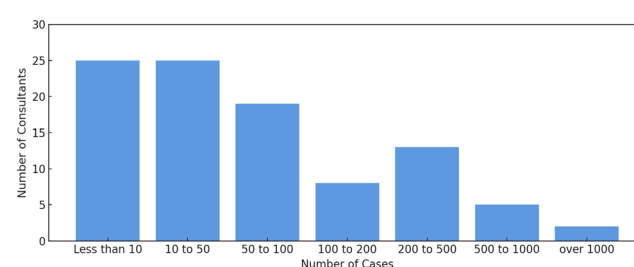


Figure 6: Case volume distribution per surgeon

Figure 3 shows the number of pathways by surgical approach. Arthroscopic surgery continues to make up the majority of procedures included in the registry. The exclusion of pathways with incomplete data has significantly reduced the number of cases where the approach was not recorded.

FUNDING SOURCE FOR SURGERY

This year's report demonstrates that nearly 65% of non-arthroplasty hip procedures carried out in the last 12 months were NHS funded. This is highest proportion of NHS funded procedures recorded in the registry since 2016. Another encouraging sign perhaps of the ongoing post pandemic surgical recovery. Nevertheless, Figure 7 demonstrates that the proportion of procedures performed in the independent sector has remained fairly static (2024- 29.6%) and decreased NHS procedure volumes continue to explain the reduced number of hip preservation surgeries undertaken in recent years.

Encouragingly funding source was stated on 94.5% of all submitted pathways in 2024 thus allowing more accurate assessment of procedure volumes in different settings. Figure 8 demonstrates the portion of NHS and independently funded procedures throughout the UK.

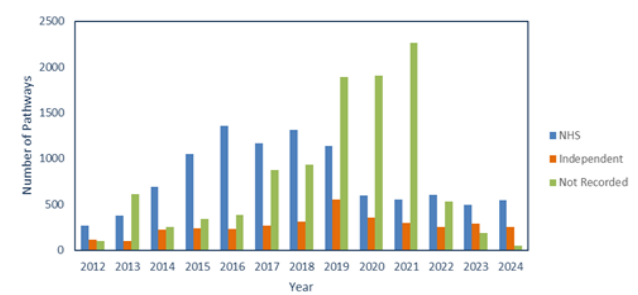


Figure 7: Funding source for procedure

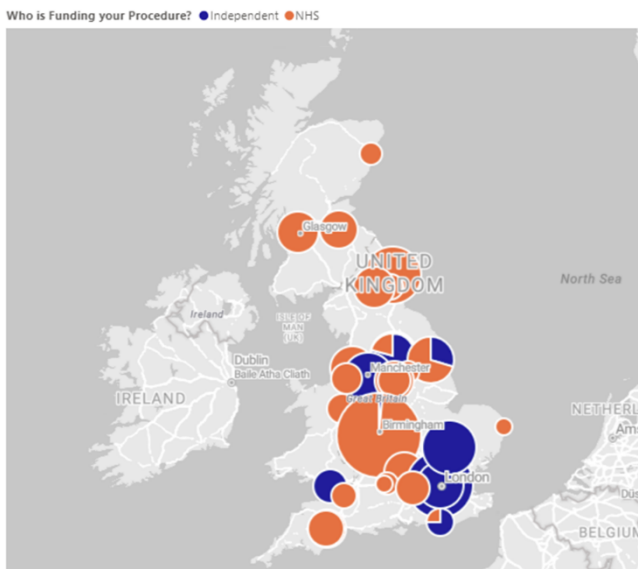


Figure 8: Funding source across the UK

DEMOGRAPHICS

PATIENTS BY AGE AND APPROACH

Figure 9 demonstrates the age range of recorded patient pathways by surgical approach. The overwhelming majority of arthroscopic and open procedures are undertaken on patients under 55 and 50 years of age respectively. The peak age range for arthroscopic procedures (n=1852) was 30-35 years while open surgery was most common in 25- to 30-year-olds. It remains the case there are a small number of cases recorded in the registry of in patients under 16 years old. Possibly due to limited number of cases recorded in the

registry of in patients under 16 years old. Possibly due to limited number of to limited number of NAHR contributing surgeons who have a paediatric practice and/or paediatric orthopaedic surgeons preforming hip preservation surgery being unaware or unsupported in data submission to the NAHR.

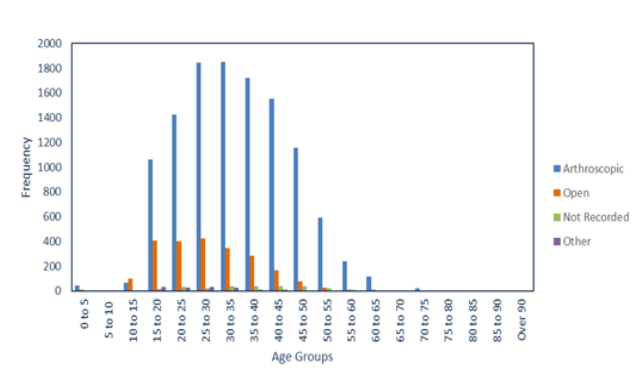


Figure 9: Patients' age distribution by approach

GENDER DISTRIBUTION BY SURGICAL APPROACH

Female patients continue account for the majority (63.52%) of patients with pathways entered on the NAHR. The gender distribution by surgical approach is displayed in Figure 10- clearly illustrating that open surgery is much more commonly performed in female patients. This likely reflects the higher incidence of hip dysplasia in females, which is most commonly and effectively managed with open surgery (e.g. Pelvic osteotomy).

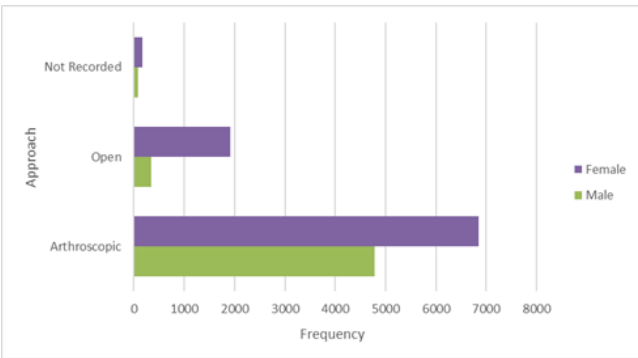


Figure 10: Gender distribution 2012 - 2024

BODY MASS INDEX (BMI) BY AGE AND OUTCOMES

Figure 11 illustrates the number of patient pathways with BMI data recorded in the NAHR since 2012.

We can see that the majority of patients have their BMI recorded at baseline, however there was a slight decrease in compliance of this variable compared to 2023 (71.8% VS 75.6% completion rate).

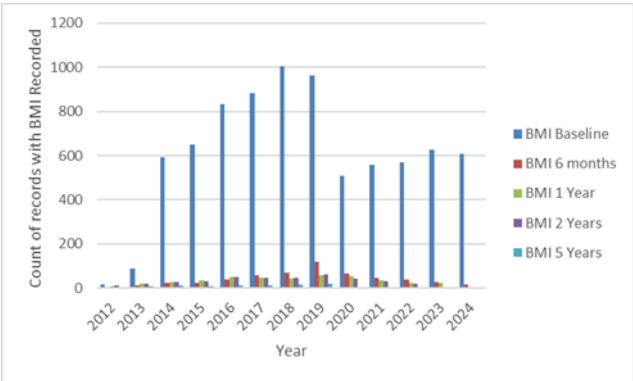


Figure 11: Number of BMI records per year

BMI distribution of all recorded patient pathways at baseline is displayed in Figure 12. Please note as with previous reports we assumed that extremes of BMI (<10 n=17 & >70 n=28) are erroneous and have therefore been excluded. Figure 13 shows the heatmap distribution of the available BMI and age ranges of submitted patient pathways. The large majority of patients continue to have a BMI< 30 with modal BMI of 24. This continues to be of particular relevance given the literature continues to suggest poorer outcomes in obese patients following hip preservation surgery. Figures 14 & 15 highlight peak PROMs scores in PAO patients within in the 20-25 BMI range and declining thereafter.

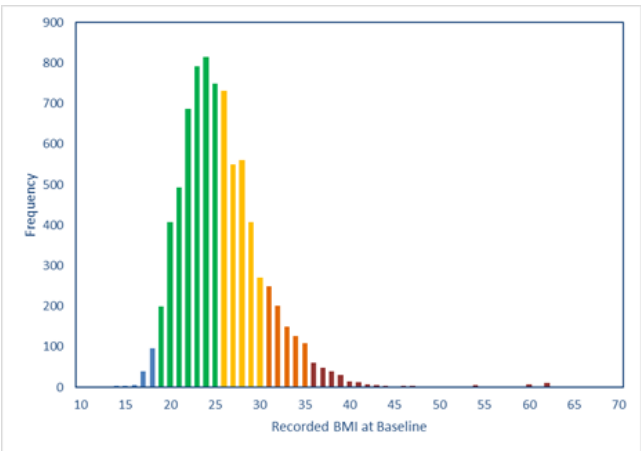


Figure 12: BMI distribution

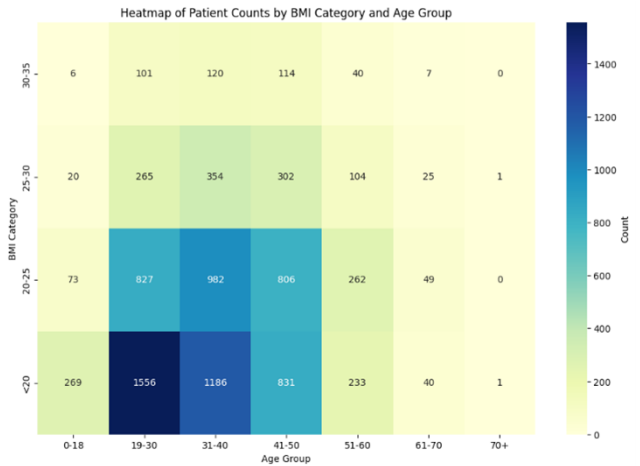


Figure 13: Heatmap distribution by age and BMI category

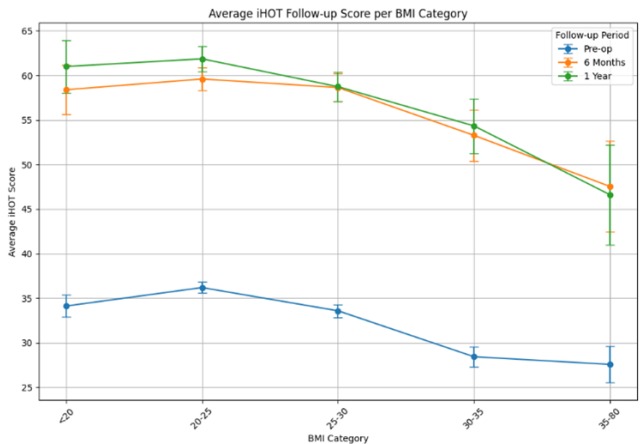


Figure 14: iHOT-12 in PAO by BMI category

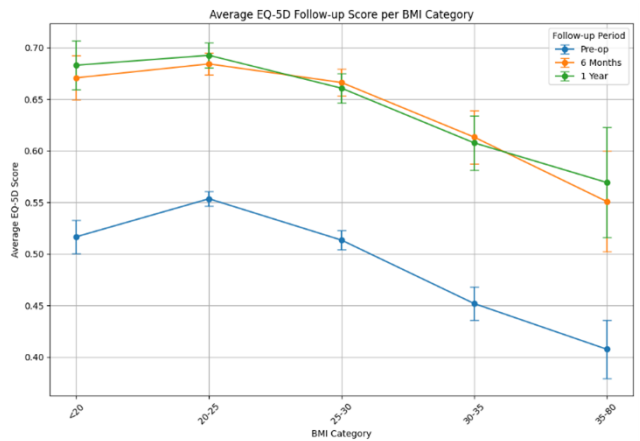


Figure 15: EQ 5D index in PAO by BMI category

COMPLIANCE

FOLLOW-UP AND DATA LINKAGE

To allow accurate assessment of hip preservation interventions high completion rates of PROMs are needed at 6, 12, 24 & potentially 60 months. PROMs are currently sent to patients automatically at the stated time points and therefore correct contact details are essential. Figure 16 demonstrates the percentage of contact details and NHS numbers linked to submitted pathways.

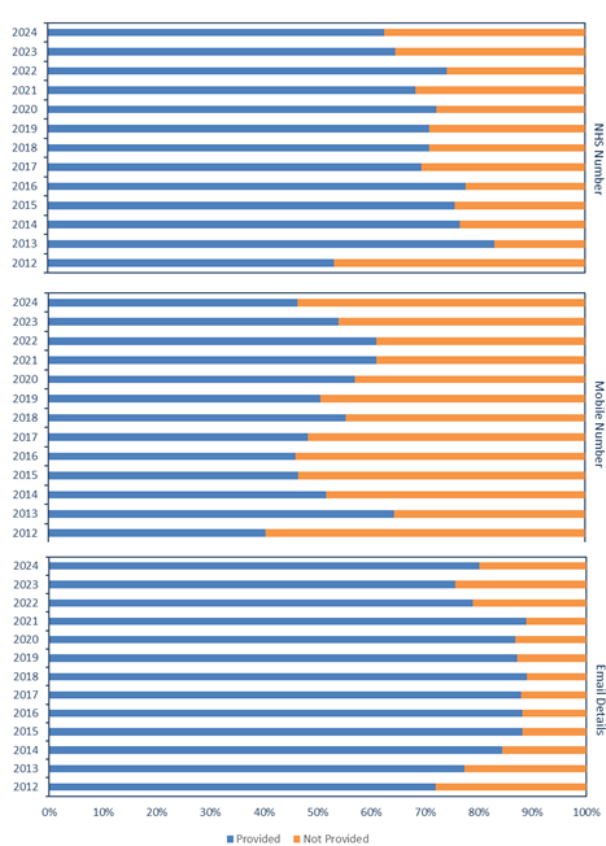


Figure 16: Patient contact details and NHS identifiers

Unfortunately, despite a modest increase in the percentage of email details recorded in 2024 both NHS number and mobile phone linkage continues to decline.

To improve data collection and outcome analysis it is crucial that there is improved recording of contact details when submitting pathways to the NAHR.

The percentage of pathways with a recorded NHS number has reached the lowest level since 2012.

This may in part be due to the logistical challenges of obtaining an NHS number for patients when operating in the independent sector. Linking of a unique NHS identifier to patients can provide advantages for data collection and analysis. Clear advice on how to obtain the NHS number for private patients is available on the NAHR pages of the BHS website and we encourage clinicians to submit this data where possible.

CONSENT RATES

Documentation of patient consent for entry of their details into the NAHR is mandatory component when submitting a patient pathway. We can see from Figure 17 the steady increase in documentation of consent for inclusion on the registry with 99.3% of records showing consent obtained in 2024.

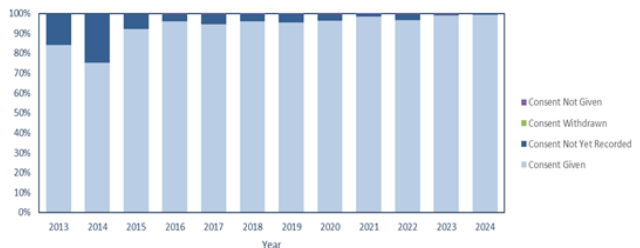


Figure 17: Consent for data collection

Of note a very small proportion of the total patients (0.03%) on the registry have subsequently withdrawn consent for inclusion.

COLLECTION OF MANDATORY SCORES AND STATISTICS

OVERVIEW OF SCORES

Although the NAHR offers surgeons the opportunity to use a variety of hip scores for outcome assessment, only two scores are mandated as part of the minimum dataset. EQ-5D-5L (including the EQ-5D-VAS) and the iHOT-12 were identity by the NAHR User Group (based on available evidence) as the key mandatory outcomes scores to be included. Scores are recorded pre-operatively then routinely, via email or in person,

at 6 months, 12 months and 2 years post-operatively. Some patients will also receive a text message reminder or telephone phone call to improve follow-up, but this is not universal. Surgeons can select to use other, additional PROM scores if desired.

EQ-5D INDEX

The EQ-5D index score is based on five domains (mobility, self-care, usual activities, pain/discomfort and anxiety/depression) each with five options (no problems, slight problems, moderate problems, severe problems and extreme problems).

EQ VAS

The EQ Visual Analogue score records the respondent's self-rated health on a 20cm vertical scale where endpoints are labelled 'Best imaginable health state' (100) and 'Worst imaginable health state' (0).

iHOT-12

This is a short form equivalent of the iHOT-33 which was developed by the Multicentre Arthroscopy of the Hip Outcomes Research Network (MAHORN). The iHOT-33 was developed for active patients (18-60 years; > Tegner 4) presenting with a variety of hip conditions. The shorter 12 question patient-derived, patient-reported outcome measure demonstrates excellent agreement with the long version with a minimum clinically important difference of 6.1 points. This report only includes the findings related to these mandatory scores. The scores are recorded as complete or incomplete and results for recent years are shown in Figures 18-19.

STATISTICAL NOTE

The analysis and visualisation of the NAHR data was primarily achieved using Pandas for data manipulation, Matplotlib and Seaborn for creating visualisations, and SciPy, version 1.7.1, for statistical analysis.

RATES OF SCORE COLLECTION

Overall, the majority of patients continue to have baseline scores recorded. However, the 2024 data do demonstrate a drop in completion rates of both baseline and 6-month PROMS across both outcome scores when compared to previous reports.

EQ-5D INDEX

As demonstrated below despite relatively high preoperative EQ-5 index completion rates this tends to precipitous drop across the 6 monthly follow up intervals. 2024 data show an 85.2% baseline completion rate falling to just 21.8% at 6 months post operatively.

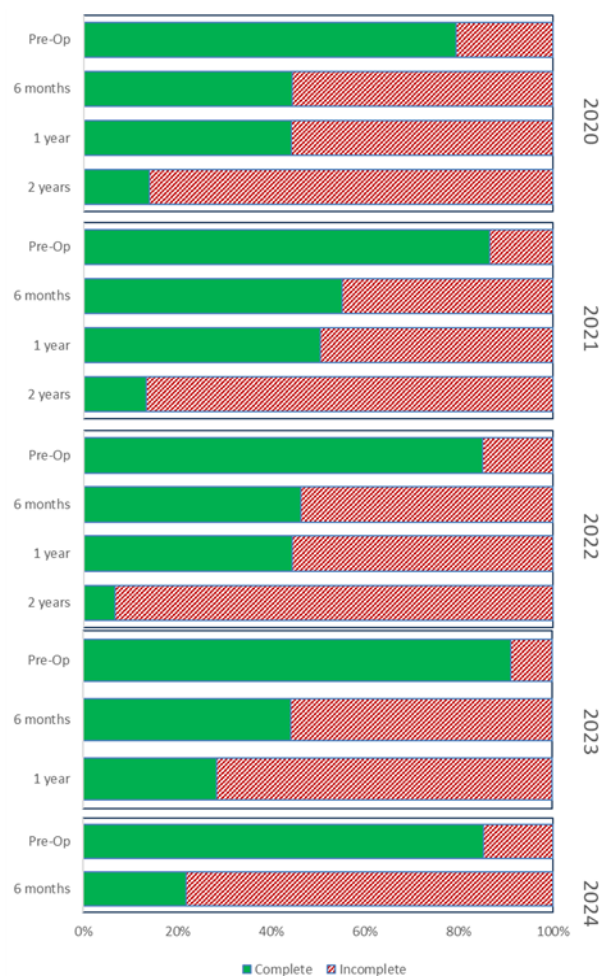


Figure 18: EQ-5D index score completion

iHOT-12

The iHOT-12 score was presented to the International Society for Hip Arthroscopy (ISHA) in 2011. Since 2014, this score has been collected as part of the same minimum scoring sheet. Similar completion and drop rates are seen as with the EQ-5D index.

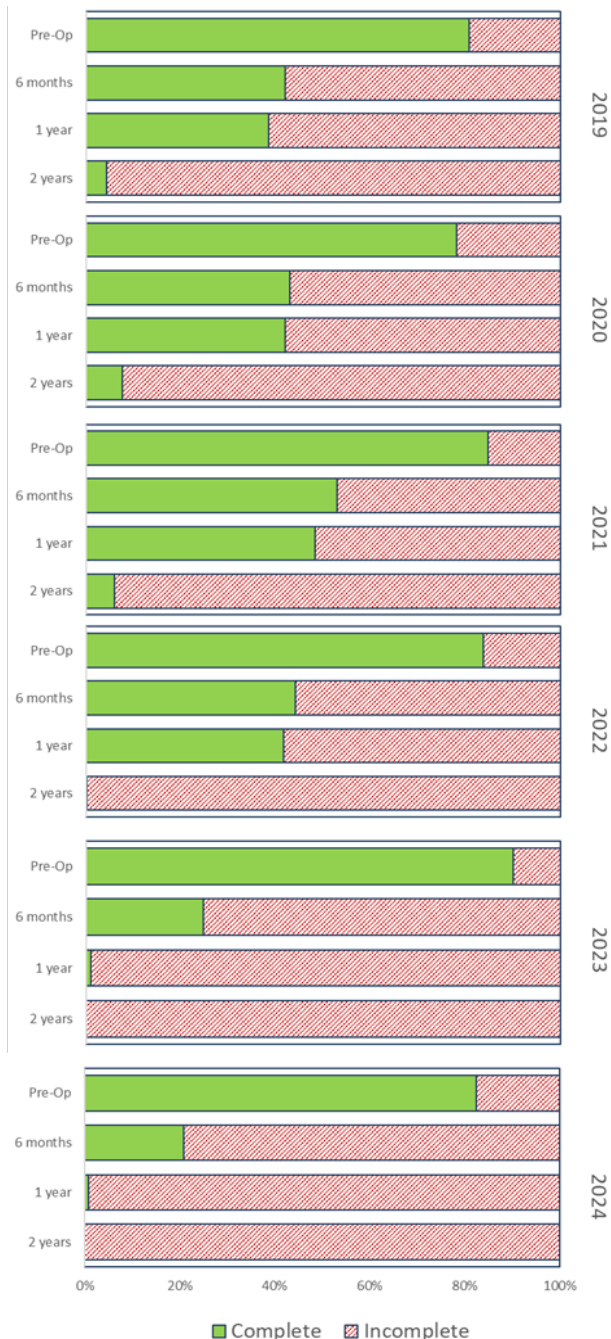


Figure 19: iHOT-12 Score completion

In summary, optimising patient engagement with follow-up PROMs remains a challenge for the NAHR. The use of e-mail, text and phone reminders as well as updating of the NAHR are measures that are being employed to improve this. Further work by the user group, in collaboration with the PROMS administrator, is ongoing and includes looking at a variety of other measures to increase completion. This remains a major focus for the NAHR in the future.

SURGICAL PROCEDURES

OVERVIEW

The number of acetabular and femoral procedures reported within the NAHR are illustrated in Figure 20 & 22 respectively. Please note each procedure is recorded as an individual case, although many will have been performed simultaneously during a single operative event.

ACETABULAR PROCEDURES

Labral repair remains the most performed acetabular procedure in the registry, with 5264 repairs recorded (Please note that multiple acetabular procedures may be performed in a single patient pathway). As shown in figure 21 there has been a steady increased in the frequency of labral repair in recent years with a reciprocal decline in labral debridement. Labral repair accounted for 68.1% of acetabular labral procedures in 2024. The reasons for increasing incidence of labral repair is likely to be multifactorial including improved surgical techniques and equipment, but also increasing evidence within the literature that labral repair appears to offer better outcomes than labral debridement. 20 cases of labral reconstruction/grafting are recorded in the register making up 0.2% of acetabular procedures, as such labral reconstruction remains a relatively rare procedure in the UK. Perhaps reflecting that although early results on the use of reconstruction for irreparable labral defects have been encouraging further evidence is needed to define appropriate patient selection for this procedure.

We have also observed an increase of acetabular pincer resection procedures as appose to rim resection and agreement on a standardised term would improve the reliability of data recorded in the registry.

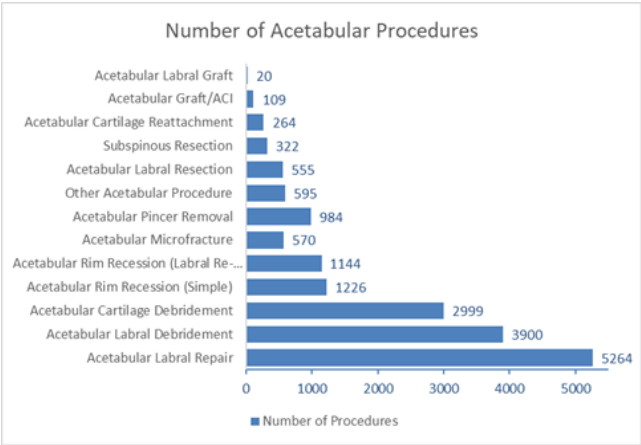


Figure 20: Acetabular procedures performed

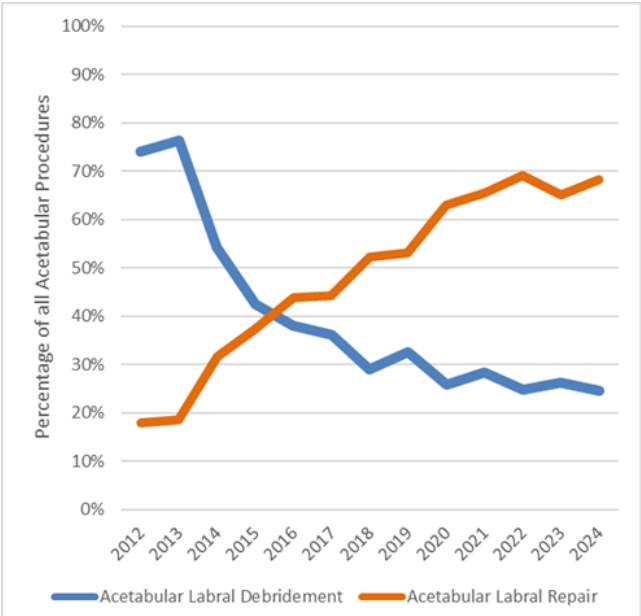


Figure 21: Comparison of labral debridement and labral repair per year

FEMORAL PROCEDURES

The range of femoral procedures recorded within the registry is displayed in Figure 22. Cam resection remains by far the commonest femoral procedure performed, accounting for 95.6% of femoral surgery. Procedures on the femoral articular cartilage were much less common than in the acetabulum with relatively low rates of microfracture, cartilage debridement and grafting/ACI.

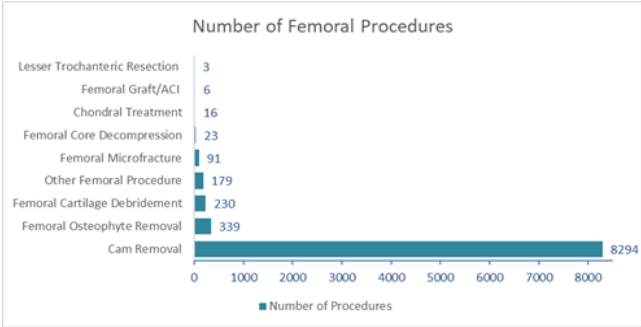


Figure 22: Number of femoral procedures performed

The large majority of periarticular femoral procedures were performed arthroscopically (Figure 23).

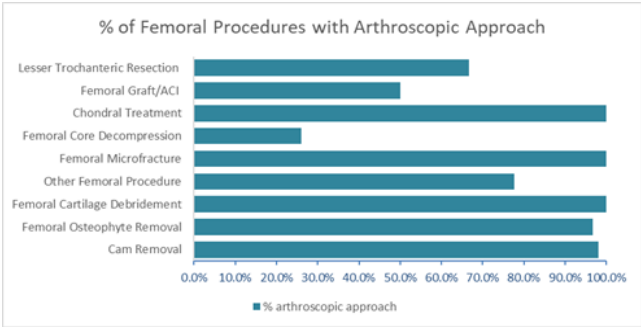


Figure 23: Proportion of arthroscopic femoral procedures

ADDITIONAL SURGICAL PROCEDURES

In addition to peri-articular non arthroplasty surgeries the NAHR records several additional techniques that are often performed simultaneously with acetabular and/or femoral procedures. These additional hip procedures usually address extra-articular and soft tissue structures. Most of these cases were performed as part of an arthroscopic approach. Figure 24 shows the frequency of additional procedures recorded in the NAHR. The incidence with which these additional procedures are performed has remained consistent. Psoas release is still the most common additional procedure performed (n=584). The board acknowledge that there are increasing numbers of prior joint replacement patients undergoing subsequent arthroscopic psoas release. Numbers of trochanteric bursal debridement (119) and ITB release (102) continue to steadily rise. Numbers of gluteal tendon repair increased in 2024 from 26 to 31, but overall numbers of this procedure remain small.

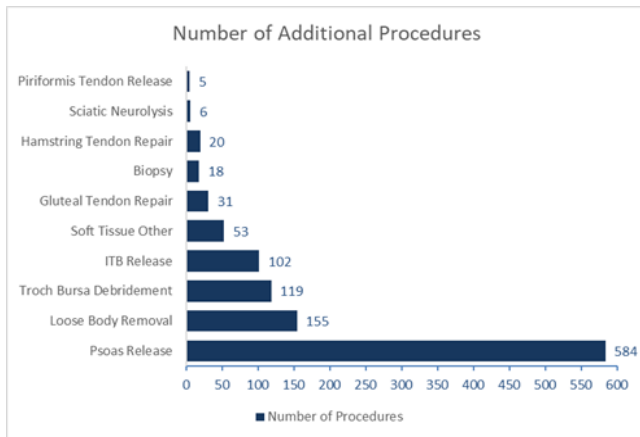


Figure 24: Additional surgical procedures

PELVIC AND PERIACETABULAR OSTEOTOMIES (PAO)

A total of 2006 pelvic osteotomies are recorded within the NAHR (Figure 25). The vast majority of these procedures were PAO (1834) followed by Triple Pelvic Osteotomy (TPO) (166). PAO was performed in both isolation and combined with femoral osteotomy in 1750 and 62 cases respectively. A total of 160 PAOs were performed in 2024 a decrease from the 237 performed in 2023. Four surgeons accounted for 78.9% of all pathways with PAO.

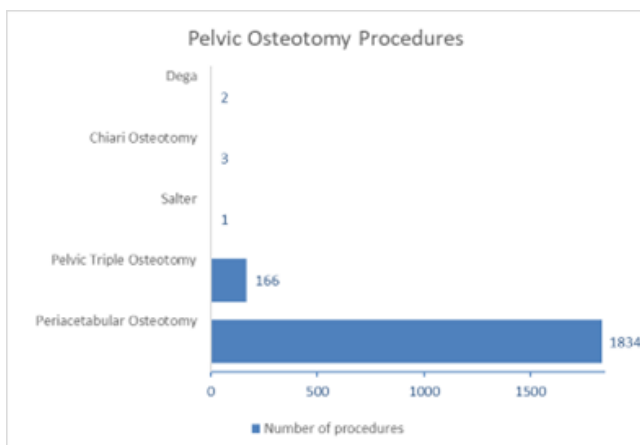


Figure 25: Percentage of PAO osteotomies performed

FEMORAL OSTEOTOMIES

The types of femoral osteotomy recorded in the register are illustrated in Figure 26. A total of 294 femoral osteotomies have been recorded in the NAHR.

Derotation osteotomy represented the bulk of femoral procedures followed by "other osteotomy" and trochanteric advancement.

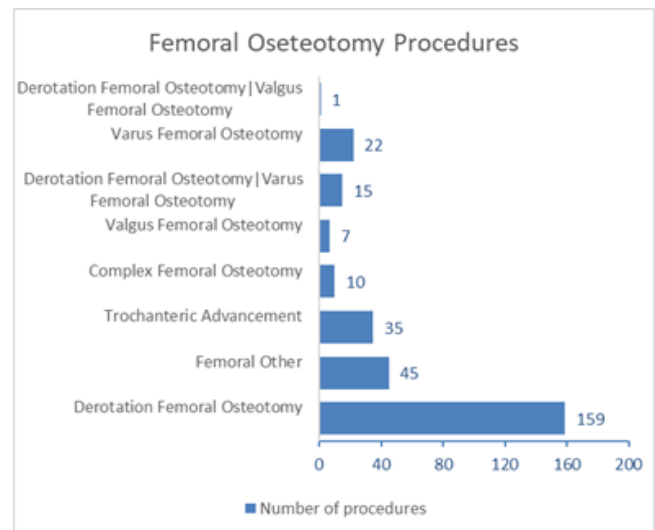


Figure 26: Number of femoral osteotomies performed by subtype

OUTCOME SCORES OVERVIEW

All scores are presented as a mean score with +/- one standard deviation error bars. In most cases, raw data has also been plotted and, where appropriate, a violin plot is also provided to demonstrate the data distribution. It is acknowledged that showing two standard deviations would show 95% confidence intervals.

OUTCOME OF SURGERY FOR FAI OVERALL

We have reported the outcomes of surgery to address FAI where cam resection and/ or acetabular rim recession/pincer removal has been performed (7215 procedures). Cases for which concurrent microfracture or other chondral procedures was performed were excluded as in previous reports. As demonstrated in figure 27-29 recorded PROMs demonstrated improvement in scores compared with preoperative levels.

There was improvement in the pre-operative iHOT-12 score by 6 months with mean scores increasing from 33.29 (n=5910) to 57.70 (n=2879) [mean change 24.91 P<0.0001 paired t test] which was sustained up until 1 year postoperatively with mean score of 58.03 (n=2499). At 2 years there was a slight reduction in iHOT-12 to 49.6 (n=271), this however remained well above baseline scores. Similarly, EQ-5D index similarly demonstrated improvements in baseline scores following intervention (Figure 28). Mean EQ5D improved from 0.52 (n=6022) preoperatively to 0.67 (n=3056) at 6 months [mean change 0.15 P<0.0001 paired t test]. However, scores steadily decreased to 0.66 (n=2647) at 1 year and 0.58 (n=621) at 2 years post operatively.

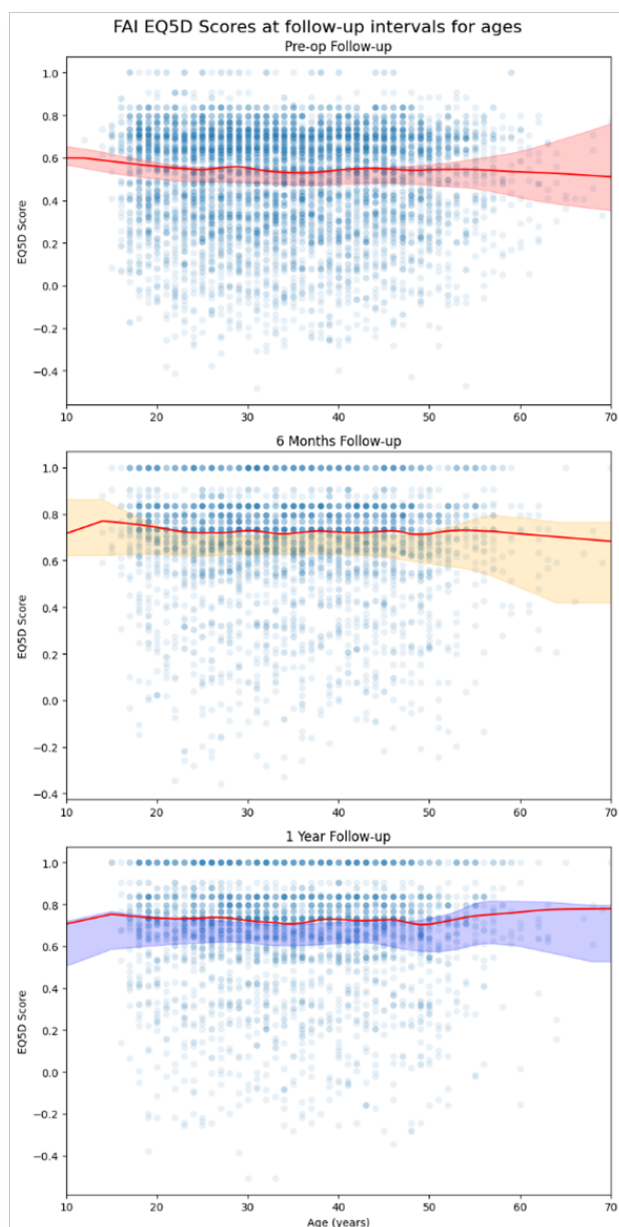


Figure 27: EQ-5D index score - whole cohort for FAI

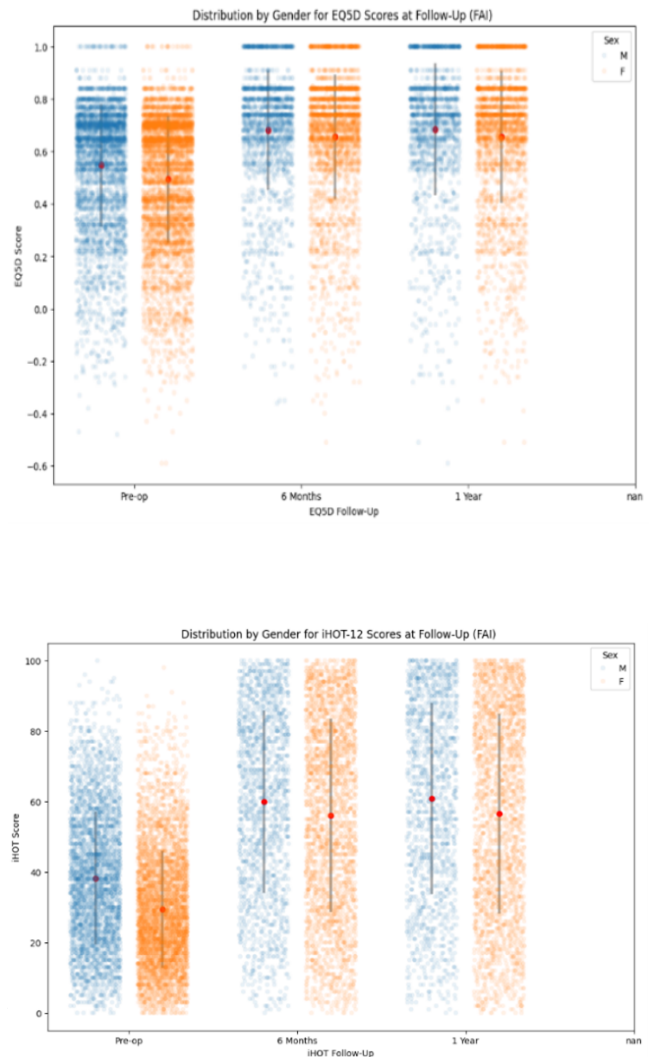


Figure 29: FAI iHOT 12 scores split by gender

RESULTS OF SURGERY FOR CAM LESIONS BY GENDER

Figure 30 shows the EQ-5D index against gender whilst Figure 31 demonstrates iHOT-12 scores in patients undergoing isolated cam removal. As identified in previous reports and the overall FAI data, females start with a lower preoperative baseline score, but this improves by one year post-operatively such that males have only marginally higher score at this time-point. Scores decline in both men and women from 1 to 2 years postoperatively but consistently remain above baseline levels at 2 years.

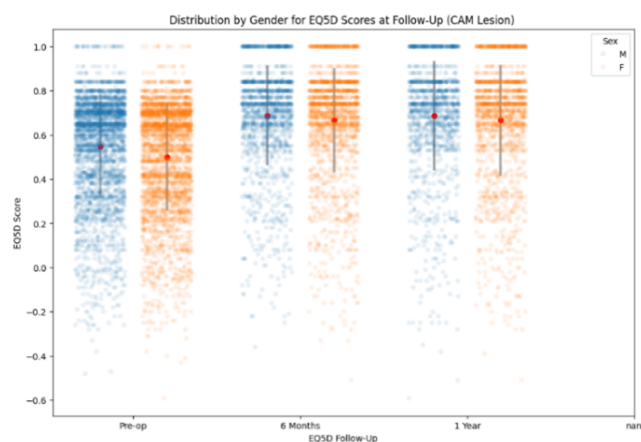


Figure 25:EQ-5D index by gender for cam resection

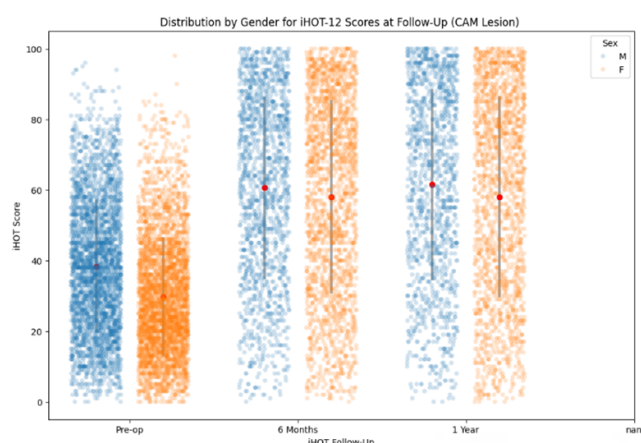


Figure 31: iHOT-12 by gender for cam resection

RESULTS OF SURGERY FOR CAM LESIONS INCLUDING BY AGE

As shown in figure 32 cam resection osteoplasty improved PROMS from baseline across the vast majority of age ranges. At 6 months post operatively IHOT-12 scores improved by 24.7 points ($P < 0.0001$) and EQ5D scores were also significantly higher. Improvements in IHOT 12 peaked at 1 year postoperatively before decreasing at the 2-year point (although still greater than baseline). EQ5D index also modestly declined between 12- and 24-months post operatively.

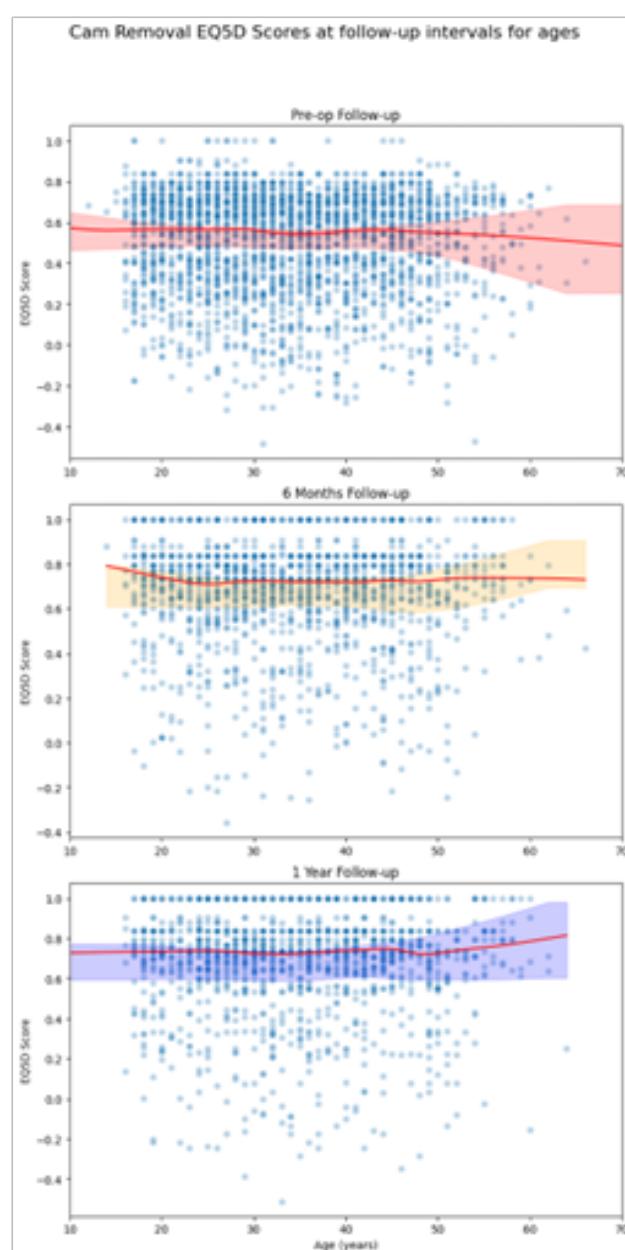


Figure 32: EQ-5D index by age for cam lesions

RESULTS OF SURGERY FOR Pincer LESIONS

In this section, outcomes of patients undergoing isolated pincer removal have been explored [614 patients]. There was improvement in pre-operative iHOT-12 scores at 6 months and 12 months post-operatively. These scores are shown in Figure 33 and Figure 34. EQ5D index improved significantly at both 6 months and 1 year post operatively when compared to baseline, (0.67 vs 0.48 $P < 0.0001$ paired t test) and (0.65 vs 0.48 $P < 0.0001$) respectively. Similarly, IHOT-12 scores significantly improved from preoperatively

levels by a mean of 23.9 ($P<0.0001$ paired t test) and 22.2 ($P<0.0001$ paired t test) at 6 and 12 months respectively. Both PROMS measures showed modest decreases from 12 to 24 months post operatively.



Figure 33: EQ-5D index - surgery for pincer lesion

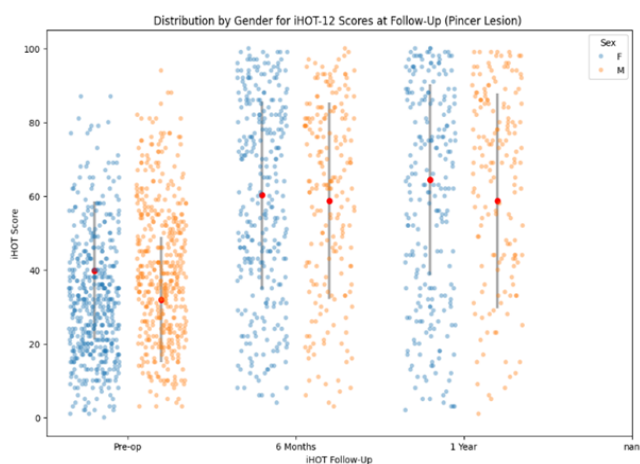


Figure 34: iHOT-12 scores - surgery for pincer lesion

OUTCOME FOLLOWING ISOLATED PELVIC OSTEOTOMY (PAO & TPO)

In this section outcomes in patients undergoing isolated pelvic osteotomy for reorientation of the acetabulum are highlighted. The total number of cases of periacetabular osteotomy was 1750 and triple pelvic osteotomies has been performed in 166 cases.

iHOT-12 & EQ5D INDEX IN PAO

For patients undergoing PAO iHOT-12 scores significantly improved from a baseline of 30.11 ($n=1498$) to 55.13 ($n=845$) at 6 months post operatively [mean change 25.07 $P<0.0001$ paired t test]. iHOT-12 scores continue to improve and peak at 1 year following surgery (mean score 62.13 $n=792$). EQ5D index also increased from a mean of 0.47 preoperatively ($n=1508$) to 0.67 ($n=880$) at 6 months and 0.67 ($n=840$) at 12 months following PAO. At 2 years follow-up there were slight reductions of both iHOT-12 & EQ5D mean scores to 55.68 and 0.61 respectively. PROMs in patients undergoing PAO are illustrated in Figure 35 & 36

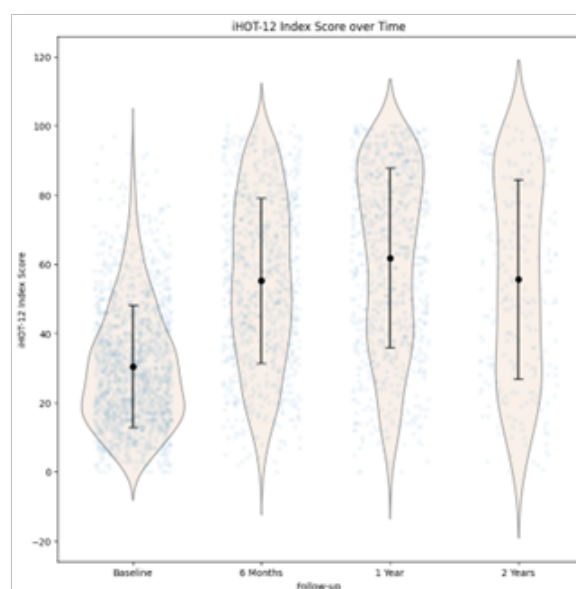


Figure 35: iHOT-12 in PAO surgery

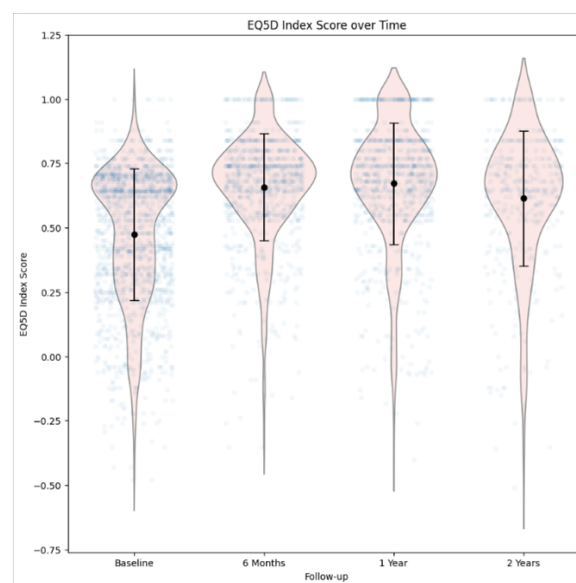


Figure 36: EQ5D index in patients undergoing PAO

RESULTS OF PAO VS AGE

In keeping with previous reports outcomes show improvements across the age ranges, Figure 34 illustrates this for EQ5D index.

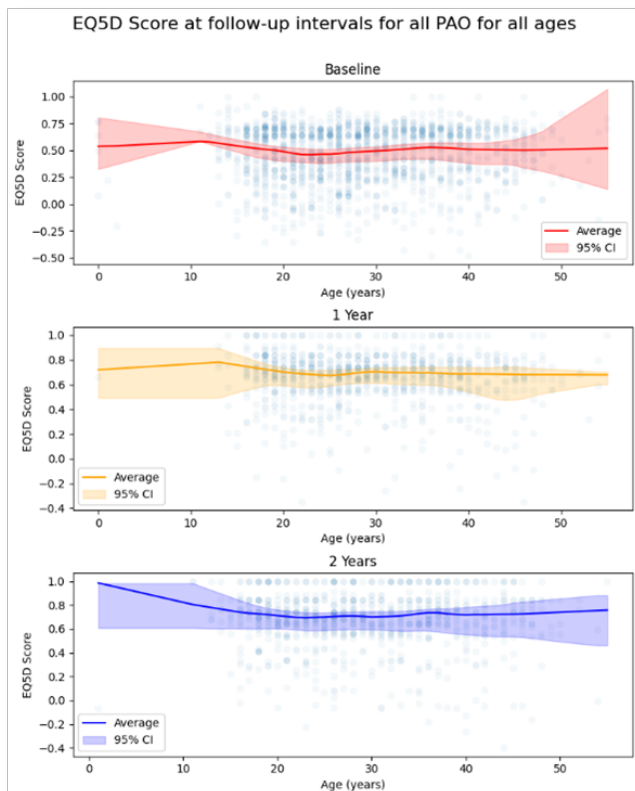


Figure 35: EQ-5D scores with age distribution for PAO patients (note due to relatively small numbers of large confidence intervals are evident)

RESULTS OF PERI-ACETABULAR OSTEOTOMY VS GENDER

As illustrated in Figure 38 & 39 both genders benefit with improved PROMS after PAO. Female patients experience greater absolute improvement in IHOT-12 and EQ5D scores in the first 12 months following surgery as they begin from poorer baseline scores. Female patients obtained peak IHOT-12 scores at 1 year postoperatively (mean score 61.61 n=730) whereas male IHOT-12 scores continued to improve at 2 years post-surgery (mean score 69.49 n=13). A similar trend was seen with EQ5D index. This suggests different outcome patterns between genders, whereby females see greater mean increases in PROMs scores in the first 12 months with outcomes declining thereafter, whereas males continue to see improvements 2 years post-operatively. Caution in drawing firm conclusions

should be observed however, as PROMS completion rates decline precipitously, and 2-year outcomes are only available for a very small cohort of patients. In any case PROMs data clearly shows substantial improvements following PAO in both genders.

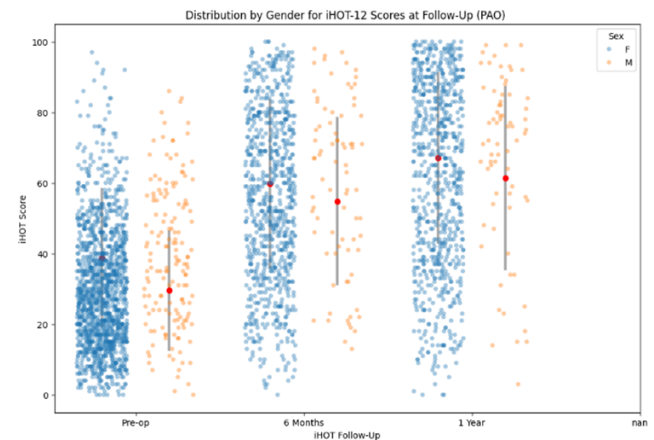


Figure 38: iHOT-12 scores with gender distribution for PAO



Figure 38: EQ-5D scores with gender for PAO

RESULTS OF PAO WITH BMI

As highlighted previously in this report (page 16) patients with raised BMI tend to have poorer outcomes post operatively. Figures 40 & 41 demonstrate in further detail that outcomes at all time points are poorer with PAO in overweight patients, particularly in those with a BMI above 30.

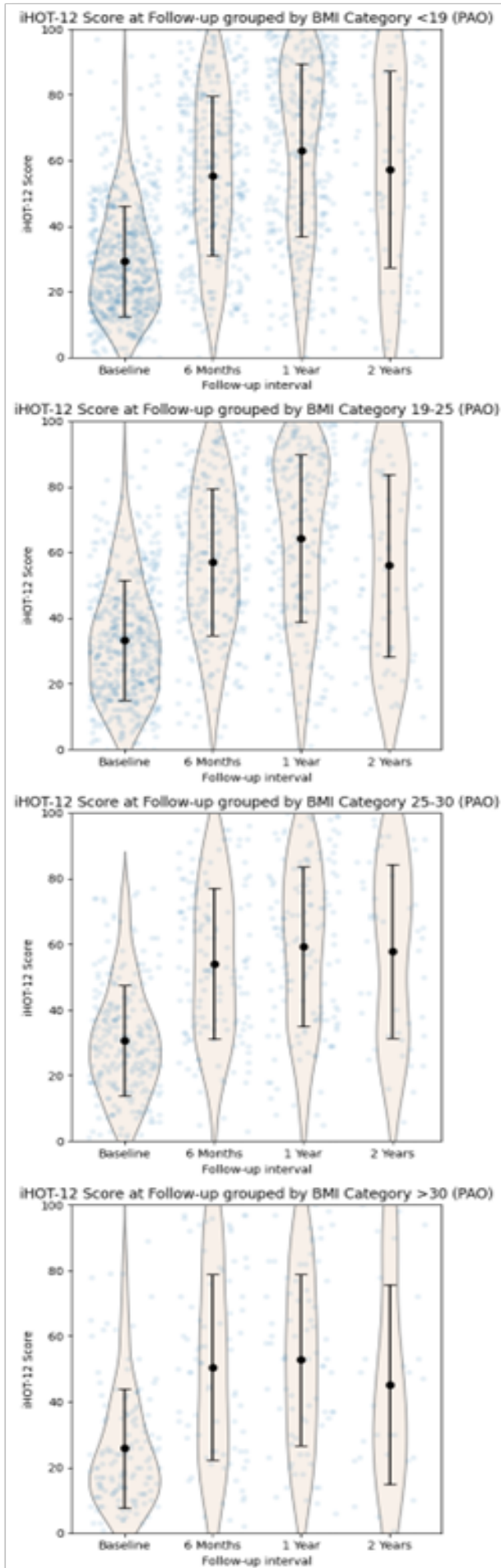


Figure 40: iHOT-12 scores with BMI distribution in PAO patients

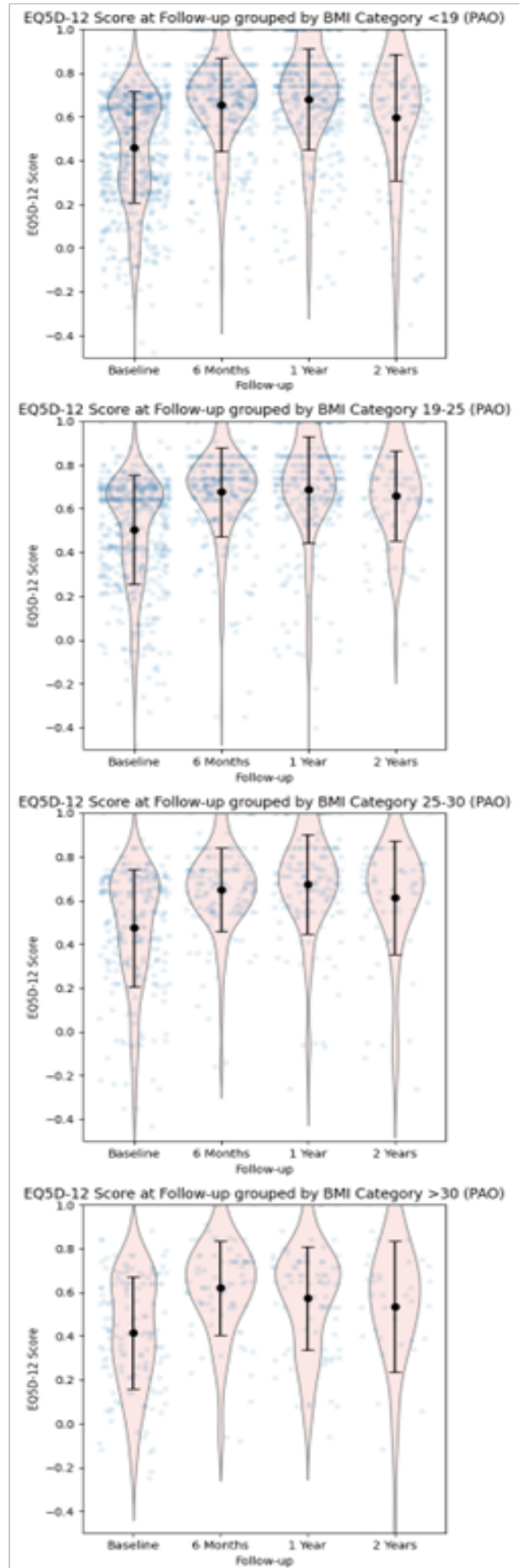


Figure 41: EQ5D scores with BMI distribution in PAO patients

OUTCOMES OF TRIPLE PELVIC OSTEOTOMY

The registry contains much fewer number of patients that have undergone TPO and as such direct comparison with PAO outcomes is not currently possible. Nevertheless, patients undergoing TPO also experienced significant improvements in PROMs in the post operative period. IHOT-12 scores significantly increased by a mean of 16.44 at 6 months ($P<0.0001$ paired t test) and 22.67 ($P<0.0001$ paired t test) when compared to baseline. Unfortunately, 2 years IHOT-12 data was only available for 9 patients' but did show a decline in outcome. EQ5D showed significant mean improvement from baseline to 6 months post operatively (mean increase 0.11 $P=0.009$ paired t test). As greater numbers of TPO procedures are recorded in the registry future, a more in-depth assessment of patient outcomes should be possible.

SUMMARY

This report underscores the significance of a registry dedicated to non-arthroplasty surgical treatments, offering invaluable insights to clinicians, patients, and policymakers. The NAHR remains an invaluable resource although the number procedures entered continues to be significantly lower than pre-pandemic levels. It also remains uncertain why the number of surgeons inputting data into the NAHR continues to decrease dropping to 34 in 2024. The possible consolidation of hip preservation expertise in a smaller number of high-volume surgeons remains a distinct possibility.

In keeping with previous reports PROMS from the registry continue to demonstrate the substantial benefit to patients undergoing surgery for femoroacetabular impingement and acetabular dysplasia. Compliance with data entry remains a challenge particularly with attrition of PROMS completion throughout follow up. Hopefully continued engagement with surgeons and patients, as well as potentially improved digital platforms will improve this in the future.

Following the introduction of the MDS 3.0 the registry is now also collecting data on several other aspects of non-arthroplasty hip procedures such as the number and type of anchors used, capsular management, acetabular cartilage repair techniques, novel soft tissue procedures, and interventions to prevent thrombosis, heterotopic ossification, adhesions as well as other adjuncts such as platelet rich plasma. The collection of this data is increasingly important following the publication of the Cumberlege report which highlighted the essential role of registries in monitoring implanted medical devices.

Anchors used for labral repair are considered an implanted medical device and thus it should be mandatory that when used data should be entered onto the NAHR.

Improving both the quality and quantity of data within the registry is vital to allowing a more in depth understanding of hip preservation with the UK. We hope that as further data is collected, we can analyse outcomes in greater details to be able to determine optimal treatment strategies for specific conditions and patient groups.

Finally, the BHS and NAHR would like to again thank members of the user group along with all the surgeons, administrative staff and patients that have contributed data to the registry, allowing the NAHR to continue to lead the way as a voluntary registry of non-arthroplasty hip procedures.

FUTURE

Surgeon engagement and patient compliance continue to be common problems for all Orthopaedic registries. With the advent of the Medical Device Outcome Registry programme by NHS England, this promised to be an opportunity for the NAHR to overcome these difficulties in the future. However, NHS England and its Outcomes and Registries Programme has run into some logistical issues that mean that there is still no concrete plan for the launch of their Outcomes Registries Platform.

There are plans to develop further **nested trials within the registry**. Ongoing collaboration with industry partners will clarify how these plans may then require changes in the MDS. As the registry continues to mature this may require changes in the dataset. Discussion on MDS 4 has already commenced.

It is hoped that **the regional representatives** will be able to motivate their colleagues, driving surgeon engagement and facilitating adoption of registry data input in their regional centres.

As the number of registries capturing data on hip preservation procedures grows around the world this then opens opportunities for **collaboration with other registries** and learn from the merged data sets.

As the number of registries capturing data on hip preservation procedures grows around the world this then opens opportunities for **collaboration with other registries** and learn from the merged data sets.

HipSTR, The North American Hip Surgical Treatment Registry

went live on 24th July 2023. They have now produced their first annual report, reporting on 1098 hip arthroscopies performed in the 2023 calendar year, detailing the demographics and surgical data for those patients.



This means that along with the **Danish Hip Arthroscopy Registry**, there are now three registries capturing data on hip arthroscopy procedures. **ISHA – The Hip Preservation Society** have a registries' committee which includes the registry leads of all three currently active registries, and whose remit includes a project to merge the common data points from all registries.

The educational and research opportunities from the NAHR data continue to grow. More papers will be published and more presentations delivered at national and international meetings.

The future continues to be bright for the **NAHR!**

NAHR REGIONAL REPRESENTATIVES



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Ashwin Kulkarni

University Hospitals of
Leicester NHS Foundation
Trust

DATA SUBMITTED DURING 2024

HOSPITALS

Alder Hey Children's NHS Foundation Trust, Liverpool
Wansbeck General Hospital, Ashington
Wrightington Hospital, Wigan
Royal Infirmary of Edinburgh, Edinburgh
Spire Manchester Hospital, Manchester
Guy's Hospital, London
University College Hospital, London
Doncaster Royal Infirmary, Doncaster
Royal Berkshire Hospital, Reading
Spire Cambridge Lea Hospital, Cambridge
Weston General Hospital, Weston-super-Mare
Chapel Allerton Hospital, Leeds
Hexham General Hospital, Hexham
Royal Orthopaedic Hospital, Birmingham
Robert Jones & Agnes Hunt Orthopaedic Hospital, Oswestry
London Clinic, London
Nuffield Health Exeter Hospital, Exeter
Royal Devon & Exeter Hospital, Exeter

Hereford County Hospital, Hereford
Spire Leeds Hospital, Leeds
Spire Hull And East Riding Hospital, Hull
Princess Grace Hospital, London
James Paget Hospital, Great Yarmouth
Colchester General Hospital, Colchester
Gartnavel General Hospital, Glasgow
The Vale Hospital, Hensol
Royal Victoria Infirmary, Newcastle Upon Tyne
Sheffield Children's Hospital, Sheffield
Leeds General Infirmary, Leeds
Nuffield Health Glasgow Hospital, Glasgow
Nuffield Health Leeds Hospital, Leeds
Spire Leicester Hospital, Leicester
Royal Hallamshire Hospital, Sheffield
Fortius Clinic, London
NHS Nightingale Hospital Exeter
Royal Derby Hospital, Derby
Nuffield Health Cambridge Hospital, Cambridge

DATA SUBMITTED DURING 2024

SURGEONS

We are grateful to the following individuals who have submitted their data to the Non-Arthroplasty Hip Registry during 2024. Their support, appreciation and understanding of what the NAHR is trying to achieve are appreciated.

Adam Cohen
Adekoyejo Odutola
Ajay Malviya
Alistair Gray
Angelos Politis
Ashwin Kulkarni
Asim Rajpura
Callum McBryde
Christopher Talbot
Christos Paliobeis
Colin Holton
Hiren Divecha
Jonathan Hutt
Marcus Bankes
Matthew James Wilson

Max Fehily
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Nic Wardle
Paul Gaston
Phillip Thomas
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Non-Arthroplasty Hip Registry

