



# **BRITISH HIP SOCIETY** Affiliated to the BOA

35 - 43 Lincoln's Inn Fields, London WC2A 3PN Tel: 020 7405 6507. Fax: 020 7831 2676

## **BRITISH HIP SOCIETY**

### **NEWSLETTER**

## **BRITISH HIP SOCIETY NEWSLETTER 2012**

### **Officers of the British Hip Society**

**President:**

Gordon Bannister – Bristol

**President Elect:**

John Timperley – Exeter

**Vice President Elect:**

John Skinner – RNOH, Middlesex

**Immediate Past President:**

John Hodgkinson – Manchester

**Honorary Secretary:**

Fares Haddad – UCL, London

**Honorary Treasurer:**

John Nolan – Norwich

**Editorial Secretary:**

John Skinner – RNOH, Middlesex

**Member at Large:**

Jonathan Howell – Exeter

**Web Master:**

Richard Field - Epsom

## **PLANS FOR BHS PRESIDENCY**

### **Gordon Bannister - President**

The realistic plans of any BHS President must harness the mood of the membership.

The membership is rising, meetings are becoming better attended and competition to present papers increasingly competitive. The BHS is unique in bucking the trend of other societies towards ever larger meetings, low thresholds for acceptance of papers, simultaneous presentations to small audiences and vast areas devoted to commercial exhibitions. Our advantage is a society of manageable size in which members know each other and come to our annual meetings to renew acquaintances and share and discuss their problems.

The standard of discussion of papers at the BHS is high and this is exactly how the scientific process should operate. A presentation is a preliminary communication that is improved by discussion with one's peers helping the work towards publication. I am concerned that there has been a tendency for members to be talked at rather than involved in meetings and I plan to give more time for discussion in Bristol next year on 27/2/13.

Our recent meetings have been dominated by the complications of metal on metal hip resurfacing and replacement and I detect an air of detachment and decreasing enthusiasm amongst the membership, many of whom have had very satisfactory results with these devices, particularly in younger patients for whom we had little to offer before. The Executive Committee is currently producing a detailed, balanced document with management pathways that gives clear guidance for the follow-up and management of the cases with implants at higher risk of failure. I hope this will limit the amount of time we spend on the subject at the next annual meeting and

allow us to explore other neglected areas of hip surgery.

The metal on metal episode has placed orthopaedic surgeons on the back foot and the response by our professional bodies has been necessarily reactive. This is disappointing when one considers previous experience with the 3M Capital Hip, polyethylene irradiated in air and increased wear of polyethylene liners in uncemented cups. The tale is a familiar one. An iterative or novel implant is produced, surgeons are approached by companies to implant them, surgeons perceive problems and feed back to industry, companies advise surgeons that their technique is at fault and after due delay, the device is withdrawn as quietly as possible. It is quite clear that the BHS needs to be involved in the process of making innovation as safe as possible to pre-empt a further repeat of this experience, be proactive if similar problems arise again and that will be a major aim of my presidency.

The BHS is tending to become the British Hip Replacement Society and many members have an interest in and commitment to the care of patients with Proximal Femoral Fractures. I would like to have a free paper session devoted to the subject at the Bristol meeting to revive the breadth of the material we cover.

Finally, our CTs and junior STs need to learn the principles of surgical access and hip arthroplasty and gain hands-on experience on sawbones before operating on patients. A number of courses exist and some members of the Society devote many hours to these. These vary in price and location and study leave budgets are parsimonious. I would like to liaise with the organisers of these courses to share teaching material and try to reduce the costs for the hip surgeons of the future. I

would hope to be able to use the videos of surgical approaches prepared by members

for the BOA presentations to allow a wider audience to benefit from them.

## **REFLECTIONS PROMPTED BY A YEAR AS PRESIDENT!**

### **John Hodgkinson – Immediate Past President**

It has been an honour and a privilege to be President of the BHS in 2011–12. Significant things have happened over the last 12 months that have made me reflect not only on the year but also on some of the changes that have taken place in medicine and of course orthopaedics in particular during my medical career.

My generation has guided and overseen a time of great development and change. It does worry me however that we have allowed too many important decisions to be taken out of clinicians hands and this may have compromised our professional position overall. Although there is a lot said about quality and safety the main focus over the last few years has been about economy. One of the clearest recent examples of this, in my opinion, has been in relation to the introduction of the enhanced recovery programme for hip and knee replacement. No one wants patients to stay in hospital longer than is necessary but not all patients have support at home. It was ‘sold’ on the understanding that it would provide patients with better care and an improved rehabilitation programme in the comfort of their own home, whilst in fact what has happened is that patients are simply told they will go home on day three. There has been no additional resourcing or education for healthcare in the community in respect of the level of care that these patients might need. We could rather have adopted the American model that transfers patients to a rehabilitation unit at three days where a reduced level of medical care is provided but they receive appropriate education, intensive physiotherapy and confidence in their surgery is thus assured. This has to be

better than discharging patients to a home alone scenario with no relatives nearby and with a district nurse service that only comes to check the wound at two weeks.

Another example is long term follow up. Hip arthroplasty is an excellent operation for pain relief however it is still major surgery. It is totally inappropriate for patients to be discharged from further follow up 6 weeks after their surgery. This is what is now being proposed by PCTs and private health providers. The introduction of arthroplasty care practitioners has been an advantage to patient care. They provide an easy access point and appropriate advice to the mentally anxious arthroplasty patient in both the early and long term scenario. Hospital based, they have access to the orthopaedic team that has given the surgical treatment in the first place and this practice is to be encouraged.

The metal-on-metal situation has highlighted the need for follow up on a different level and had it not been for the National Joint Registry highlighting the problems relatively quickly it would have been worse. We have to be careful in encouraging developments and ensure that they are based on secure data that demonstrates long term clinical and radiological success. Small changes in design can cause catastrophic results and manufacturers can not be allowed to market widely new prostheses unless they have been proven in small ethically approved long term clinical trials.

As a profession we should not accept change for change’s sake. Health care is not an arena where one size fits all. We

need to ensure that clinicians re-engage and take a major role in decisions that affect the care of their patients. This means that we have to take back some of the control that appears to have slipped away. For example, we need to return to named referrals and have a team with a leader accountable for the patient. Named referrals, as they did in the past, would help to ensure that there is a clear

identification of accountability. We would be starting again to have team responsibility for the patient. In small ways like this we can change the ethos for the better and return to improved patient care.

## **TREASURER'S REPORT**

**John Nolan**

### **Trade marking the BHS logo.**

In May 2011, the BHS executive was informed that a number of unauthorised attempts had been made to register the British Hip Society name as a network brand with Asian domain names.

The executive took advice from a specialist law firm and concluded that the simplest and potentially most effective way of protecting our name was by registering the BHS logo as a trade mark.

The necessary paperwork was duly completed and the relevant fees remitted and the BHS logo was formally trade mark protected as of July 2011.

### **Charitable status**

Following changes to corporation tax law, we were advised by our accountant that there were major advantages in obtaining HMRC charity approval.

Subject to certain exceptions, the Society would not have to complete annual tax returns and annual subscriptions and donations could be gift aided, resulting in an additional income-tax reclaim from HMRC.

Furthermore, funds raised through subscriptions and the annual conference would be completely tax-free provided the funds were duly expended only in the course of charitable purposes.

Charitable law and taxation is complex and so further specialist advice was sought from an expert, following which the BHS executive concluded that the simplest, most reliable and cost effective way of proceeding was under the charitable umbrella of the British Orthopaedic Association.

The BHS membership approved the arrangements at the 2011 AGM.

The final version of the Memorandum of Understanding is now ready to be signed by the BHS and BOA presidents with the BHS moving to charitable status officially at the beginning of 2013.

### **Membership fees**

Membership fees had remained unchanged at £50 from the earliest days of the BHS.

The executive proposed a doubling of the membership fee for those members who were also BOA members.

It was recommended that non-BOA members should pay an additional amount to help cover the additional expenses of

The BHS account is moving from Northern Bank in Northern Ireland where it was originally established by the first treasurer, Rab Mollan.

**WILL ALL EXISTING AND NEW FELLOWS OF THE BHS PLEASE ENSURE YOU HAVE COMPLETED A NEW STANDING ORDER FORM.**

These are available from Claire Wilson at the BOA or from John Nolan (BHS Honorary Treasurer) at: [jfnolan@enterprise.net](mailto:jfnolan@enterprise.net).

**THE BHS ANNUAL MEETING 2012  
John Hodgkinson**

The British Hip Society goes from strength to strength with more than 350 delegates attending this year's Annual Meeting at the Mercure Hotel in Manchester. The format of the Meeting seems to work well and the content provides valuable information and advice for all levels of seniority. This year's Presidential guest was Kjeld Soballe, from Denmark. His contribution throughout the Meeting was excellent and he gave a superb lecture on "*The surgical treatment of the dysplastic hip by minimally invasive peri-acetabular osteotomy*". His illustrations made clear his surgical skill and expertise. His presentation was well received and he was made an Honorary Fellow of the Society.

The Meeting started on Wednesday afternoon with a combined session with BORS. There are clearly several very good research projects ongoing and we

charitable status, which the BHS remits to the BOA.

The membership approved the changes at the 2011 AGM and after further discussion and clarification at the 2012 AGM approval was again agreed.

New standing order forms have been widely circulated by email and additional copies are available.

**Financial situation**

The BHS's finances are healthy but there have been a number of additional demands on our funds. The membership fee increase is timely and appropriate.

enjoyed learning about possible future clinical application of this work. There were two outstanding papers and the prize for the best paper was shared by J. Prentice (from Sheffield) and G. Grammatopoulos (Oxford)

Later on Wednesday afternoon was the "*Emerging Hip Surgeon*" session for trainees and young Consultants (less than 5 years in post). This session was organised by Henry Wynn Jones and Andy Sloan. It is a great opportunity to share clinical problems, discuss new ways of treating old problems, make new friends and build valuable clinical networks.

Johan Witt again organised an instructional session on "*Approaches to the Acetabulum*". The numbers for this session have to be limited. It is an extremely popular session and takes a lot

of organising. On this occasion Dr Chandrashekar, the Director of the Blood Transfusion Service at Speke was very helpful and was able to provide first class facilities and cadaveric specimens to allow the practical session to go head. Thanks to Johan again for his work with this session.

The main BHS Meeting started on Thursday morning. The quality of the work and the podium presentations were excellent. 35 papers had been selected for presentation from the 240 abstracts that were submitted. The McKie Prize for the best podium presentation was won by C. McBryde [‘14 year follow up of Birmingham hip resurfacing in patients under 50 years’] and this paper will now go forward for presentation at this year’s British Orthopaedic Association Annual Congress in Manchester (September 2012). A further 90 of the abstracts were selected for poster presentation and the quality of work was high. The winner of the best poster prize was A Yeo, F Strandbi, J Buly, J Hisoler, R Field [‘Prospective randomised trial comparing anterior v posterior approach for total hip arthroplasty’]

The first topic in focus was “*The Surgical Management of Pelvic Discontinuity*”. This session was organised and chaired by Tony Clayson and the speakers included Ian Stockley, Nikhil Shah and Phil Mitchell. Pelvic discontinuity is a complex and difficult problem but the incidence could be minimised if patients were followed up appropriately and loose sockets revised early. A loose socket can often be asymptomatic for a long time. Subtle changes in position of the socket can only be recognised by reviewing serial radiographs. The importance of long-term follow up has been highlighted by metal on metal hips. There has been a recent trend to discharge hip arthroplasty patients from further routine follow up within one year of their primary surgery, and yet the “*Best Practice Guidelines*” recommends

indefinite five yearly review. The treatment of pelvic discontinuity was discussed and the importance of engaging the help of specialist pelvic Surgeons was emphasised in the management of this complex problem.

The second topic in focus was a session entitled “*The Right Care*” and was organised and chaired by Adam Brooke. His panel of speakers included Alan Nye, Andrew Thomas, David Murray and Elizabeth Wade. This session highlighted the seriousness of the economic plight of the NHS. It identified possible changes in orthopaedic practice which may save money, reduce costs and improve orthopaedic practice which may save money, reduce costs and improve efficiency. It was recognised and accepted that changes will have to be made but the importance of clinical engagement and patient safety was stressed.

The third topic in focus was a very lively and entertaining debate entitled “*This House believes that all patients over the age of 65 should have a cemented hip*”. Supporting this proposal was Jonathan Howell and Matthew Porteous and arguing against this proposal was Justin Cobb and Jeremy Latham. The session was chaired by David Murray and Laurel Powers – Freeling. This was an excellent session. We heard about the “*Cementless States of America*” and the alleged harmful long-term aspects of cement in spite of more than 50 years of successful clinical use in joint arthroplasty. In the end the House rejected the proposal. This was probably based on the final comments of Justin Cobb in his summing up in which he pointed out that if the Membership supported such a proposal then the profession would lose its ability to decide what was considered best and most appropriate for each individual patient. *This session has also been summarized below by Matthew Porteous*

We received an update from the NJR Committee and the final session provided further advice on the management and recommended surveillance of metal on metal hip replacements. The metal on metal session was videoed and should soon be available on the BOA website.

The course dinner was held on the Thursday evening. It was a very enjoyable occasion, and was very well attended. It was an opportunity to relax and enjoy a glass of wine or two after the hard work of the day. We were entertained by Paul Fletcher, an ex-professional footballer and a successful hip replacement patient. Paul is a professional after dinner speaker but gave up his time freely and the Hip Society subsequently made a donation to Breast Cancer Research which is the charity of his choice.

Earlier on the Thursday at the AGM, John Skinner was elected as the next Vice President of the Society. A very worthy appointment following on from his hard work as Editorial Secretary which he will however, continue for a further year. The British Hip Society is likely to have an increasingly important role to play in the future of British orthopaedics. Appraisal and revalidation will become increasingly important in future years and attendance at educational and instructional sessions, both within the Specialist Societies and BOA Annual Congress, may eventually become mandatory. It is important for you to support the BOA and Specialist Societies. A strong membership will ensure that the profession remains united. Please continue to support your Society and put yourself forward for election to the Executive Committee to ensure that we maintain standards and clinical excellence.

## **THE BHS DEBATE**

### **Matthew Porteous**

A new feature of the BHS meeting in Manchester was a formal debate. The motion was that “The NHS should not support the routine use of cementless hip replacement in patients over 65”. Aably chaired by Lauren Powers-Feeling (chair of the National Joint Registry) and Professor David Murray, the motion was proposed by Jonathan Howell (Exeter) and seconded by Matthew Porteous (Bury St Edmunds). Howell went through data from joint registries suggesting better results from cemented over cementless hip replacement, and supported this by papers from the literature with excellent long-term follow up studies of cemented hip of between 15 and 30 years. He also argued that the higher early revision rates and more frequent malpositioning of cementless hips suggested that these were more difficult to put in than cemented ones. He pointed out that the US, a largely

cementless nation had a 17% revision rate at 10 years, compared with cement orientated Sweden at 6.4%. Porteous supported and followed this up by looking at the reasons why, despite the evidence in favour of cemented hips, the number of cementless hips is increasing. He pointed out that the use of new and more expensive implants is very much in the financial interests of the implant manufacturers, as it boosts their profit margins. He suggested their marketing strategies mainly focus on their more profitable cementless products. He suggested that their modus operandi has been heavily influenced by the US, which provides 60% of their profit, where until recently, product use has been distorted by the tactic (for which some manufacturers have been heavily fined), of large payments to influential surgeons to use and promote “the latest thing”, coupled with direct to patient marketing. He

quoted figures suggesting the NHS could save in excess of £30 million a year in lower implant and revision costs if cemented implants were used in most circumstances.

Opposing the motion were Justin Cobb (Imperial College) and Jeremy Latham (Southampton). Cobb started by arguing that progress requires a freedom to innovate, before going onto question some of the figures suggesting that cementless hips have a better outcome. He particularly drew attention to the higher mortality rates reported in the national joint registry (NJR) for patients with cementless hips. Latham focused on the importance of surgeons to have the freedom and independence to make decisions for themselves and that if the

BHS supported the motion, this would lead to centrally imposed control of the way that individuals practice and might result in a civil war within the profession.

Following the speakers there were 40 minutes of debate with both questions and statements from the audience relating to many of the points raised by the speakers.

Before the debate started a show of hands broadly suggested a 35/65 split in support of the motion, however the arguments put by Messrs Cobb and Latham were highly effective and the motion was defeated by a 65/35 vote against.

The organisers felt that the educational objectives of airing both sides of the argument in a way that maximised audience participation had been satisfied.

## **JOIN THE BHS at THE BOA IN MANCHESTER SEPT 12<sup>th</sup> 2012**

Exchange Auditorium

0830-1000 **Free paper session** will be co-chaired by Jonathan Howell and David Sochart

1030-1200 Instructional/Revalidation session will be on **Non arthroplasty interventions for hip pain**

Moderators: R Field & F Haddad

1) John Timperley - Non Arthroplasty Hip Surgery Register

John Timperley

Session chair: R Field

2) Patho-physiology of conditions causing hip pain

Fares Haddad

3) Reading plain radiographs of the hip

Tony Andrade

4) CT and MR investigation of hip pain

Sion Glyn Jones

5) The role of dGEMRIC and its clinical significance

Tom Pollard

Panel Discussion

Session chair: F Haddad

6) The clinical results Femoral and Acetabular osteotomies

Johan Witt

7) The clinical results of FAI surgery

Richard Villar

- 8) The clinical results of extra-articular hip surgery  
9) The future of joint preserving surgery - personal view  
Panel Discussion

Vikas Khanduja  
Richard Field

1445 – 1530 **Free paper session** will be co-chaired by Andrew Hamer and Derek Pegg

1530 – 1600 **Charnley lecture** - Reinhold Ganz

1630 - 1800 **Workshop**. This will be video and lecture based.

**Optimising Primary Hip Replacement** - Chair: John Hodgkinson

16.30	Posterior approach	Andy Manktelow
16.45	Transgluteal approach	Jonathan Howell
17.00	Anterior approach	Richard Field
17.15	Cemented cup	John Timperley
17.30	Cemented stem	Gordon Bannister
17.45	Uncemented hip	Dan Berry
18.00	Opening Reception	

## WHERE ARE WE WITH METAL ON METAL HIPS?

John Skinner

It seems that press interest in metal bearing hips has died down after a frantic and very unhelpful frenzy in the early part of this year. It has brought no credit on the profession that scare stories and mistruths and innuendo have been fed into the lay press generating real anxiety in patients. There can be few orthopaedic secretaries in the UK who did any meaningful work in early March in the week after the cancer scare stories were published. Merely answering the phone to hip replacement patients in various levels of anxiety proved time consuming and all encompassing. The fact that most didn't have metal bearing implants (15% of all UK arthroplasty patients) was irrelevant: all needed their records checked and all had been scared. Theoretical and real risks are always difficult to separate, but there is a

clear responsibility for all members of the Profession to behave in the best interest of our patients. To each action there is a reaction.

New work has been reassuring with regard to cancer risk. The NJR data was published in *The Lancet* showing no increased cancer risk in the short term with hip resurfacing and MOM total hip replacements. In fact both groups 19000 HR and 25000 THR SHOWED LOWER THAN EXPECTED Incidences of cancer as compared to the general population without metal bearing implants. It is of course noted that follow up is short in this group and cohorts will need to be revisited the future. The only other point of reassurance is that it does seem to be compatible with the epidemiological work

of Visuri, published on this subject in the past.

Hip resurfacing continues to have a role and excellent results continue to be published in men under 65 years. The revision rate in this group of men in the Australian Joint Register seems to be lower than the revision rate for the same group of men undergoing total hip arthroplasty at 9 years. In all series the results in women are less good and whether this relates to head size (<46mm fairing much less well), functional anteversion, offset, activity or susceptibility to effects of metal particles, remains unclear.

The British Hip Society has recommended that large diameter metal on metal bearing total hip replacements should no longer be performed for primary hip arthroplasty, except as part of a research study. The reason for this was simply that the results seem less good, there was uncertainty regarding the role of the taper or the bearing surface in generating problems and there was no clear advantage perceived for the long term. There are, however, potential advantages in hip resurfacing. Although this may disadvantage a small

number of groups, the NJR results are such that the majority results are clearly not reaching the levels of the best. Until we understand why, it is felt that this option is best avoided. The NJR has shown that metal on metal bearings greater than 32 mm have a three times greater revision rate than metal on polyethylene bearings of the same size.

Follow up of all patients with metal bearings continues to be an important part of practice in hip surgery. This needs to be tailored to the groups being investigated. There seems to be less concern for BHRs in men compared to women, 28mm MOM THRs compared to larger sizes and most concern for ASR, ASR XL and large diameter resurfacing heads on stems. The ASR, MITCH and R3 devices have all now been withdrawn.

Follow up consists of clinical evaluation of function, metal ion assessment and cross sectional imaging either USS or MRI. More useful information and assessment of tissue damage is being reported with MRI scanning using metal artefact reduction sequences.

## **INDEPENDENT PRACTICE Fares Haddad**

THE BHS is a member of FIPO and is working with BASK and the BOA to deal with some of the major challenges that the private insurance providers are throwing in the path of orthopaedic surgeons. Please find below the latest FIPO Newsletter (May 2012).

There is a great deal of ongoing work in this area. Please don't hesitate to contact me if you have any queries.

There are major changes in private medical insurance (PMI) which need the urgent attention of all consultants in private practice.

## **COMPETITION                      COMMISSION INQUIRY**

The OFT market study has concluded that there is a wider need for a Competition Commission Inquiry in to the whole independent healthcare sector. The OFT report may be seen here <http://www.oft.gov.uk/OFTwork/market-s-work/private-healthcare/>

This report contains several important points made by FIPO and we are quoted in various places but the report has largely excluded the insurers from analysis. We have now submitted further initial evidence to the Competition Commission but their inquiry may take up to 18 months.

A useful outcome from the OFT review was the undertaking given by health insurers to the Financial Services Authority that they would either pay consultant charges or advise their customers of the likelihood of a shortfall at both the point of purchase and the point of claim. For the first time, this will allow consumers to choose between those insurers that pay consultant charges and those who do not.

## **INSURANCE CHANGES**

Bupa Insurance has adopted a new strategy with several different tactics. Attempts to engage Bupa in negotiation by several professional groups have been largely rebutted.

### **• Preauthorisation**

For certain procedures (knee arthroscopy and some shoulder operations) Bupa is now demanding that consultants send a detailed pro forma which they will vet before agreeing funding for surgery. The BOA/BASK/FIPO have objected strongly to this and in particular to the introduction of insurance-based clinical guidelines and external review by clerical staff or doctors who have never seen or examined the patient. The Royal College of Surgeons of England was clear and supportive over this matter of distant second opinions.

### **• Patient Reimbursement Changes**

Bupa benefits to patients for their consultant fees have been slashed across the Board in many specialties (including ENT, endoscopy, dermatology/plastic surgery, urology, gynaecology, orthopaedics) with some reductions of up to 55%. More cutbacks are anticipated. For clarity, in these specialties Bupa have also

raised reimbursements for a small number of procedures, but these are procedures are less commonly performed. The reduction in 39 fairly common procedures in these specialties amounts on average to a 32.25% cutback which equates with an average reimbursement reduction to patients for their consultants' fees of £213. These reductions apply to rates which have remained largely unchanged since 1993.

In addition, Bupa has reduced benefits in certain fields such as cardiology for specialised tests i.e. echocardiography in a complex arrangement. Consultants are being asked to sign up to this massive reduction or their patients will not be reimbursed for these services i.e. these consultants will be unable to perform these tests for patients under their Bupa insurance. This latter approach is similar to Bupa's previous tactic with physiotherapists who were asked to commit to lower reimbursements or face delisting.

### **• Bupa Open Referral**

Consultants may be aware that Bupa's Open Referral policy applies to a number of corporate subscribers and some personal subscribers. Essentially the normal GP to consultant referral pathway is broken and the patient is offered the name of alternative consultants at preauthorisation based on Bupa's list of consultants who have agreed (or been forced) to charge within the Bupa reimbursement levels. We think that consultants have a right under the Data Protection Act to see the data held by Bupa about them. We would remind consultants that their contract is with the patient who is ultimately responsible for their fee. Patients may have different insurance cover (and thus benefits) and any shortfall on consultant fees is their responsibility.

In forming various partnerships with consultants BUPA excludes the patient from the equation and thus locks

consultants in to a reimbursement rate set by the insurer. Of course this payment may well be further reduced in the future (as experience has shown in the USA where this tactic has been imposed by various insurers).

## **FIPO CONSULTANT SURVEYS - WHAT DO CONSULTANTS THINK?**

FIPO has received many emails and letters from consultants and together with ENT-UK, the British Society of Gastroenterology and Association of Coloproctology of Great Britain and Ireland has organised two Survey Monkey questionnaires with over 700 respondents. The results have to be interpreted within the context of the arrangements that consultants may have with Bupa which may involve the following

1. Newly appointed consultants who are being placed onto a fixed fee schedule by Bupa (and AXA PPP) and who have no option but to accept or fail recognition.
2. The “old” Bupa Consultant Partnership in which consultants agreed to charge within Bupa reimbursement rates and received a small annual bonus for operative procedures only.
3. A Fee Assured Partnership based on a more recent detailed contract issued by Bupa and in which consultants must adhere to Bupa rates.
4. Consultants who have no Partnership arrangement with Bupa and who make their own charges.

At Bupa’s own hospital, the Cromwell, less than 50% of consultants are ‘fee assured’.

**The Consultant Survey Monkey results seem fairly clear.**

- *Young consultants on the fixed fee schedule (which also may involve AXA PPP) are overwhelmingly critical of this arrangement and very few receive any extra referrals via the insurer.*
- *There are very few consultants who have been tempted to sign the latest*

*“Fee Assured Partnership contract” with Bupa.*

- *Consultants in the older Partnership do not now all receive the annual small bonus (and the future of this bonus appears to be threatened).*

**The responses in the Survey Monkey questionnaires about consultant intentions depend on the respondents’ relationship with Bupa.**

- *Newly appointed consultants in a fixed fee “Partnership” would all wish to withdraw but are prevented from doing so.*
- *The majority of consultants outside of any Bupa Partnership will not accept the new Bupa reimbursement rates and will continue to set their own fees.*
- *The majority of consultants within the old Bupa Partnership and the very few consultants in the new Fee Assured Partnership with Bupa are intent on withdrawing.*
- *However, overall 25% of consultants are unsure of how to react to the current situation and are seeking advice.*

## **WHAT CAN CONSULTANTS DO?**

- **Should consultants remain in or join a Partnership arrangement with Bupa?**

Clearly consultants are faced with a difficult decision which must be taken personally. Some are fearful that other colleagues may have some advantage if they withdraw from a Bupa Partnership.

Consultants should consider the facts. For example, would remaining in a “partnership” with an Insurer mean that a consultant loses the contract with the patient, leading to

- a total loss of professional independence
- no guarantee of any future reimbursement increases (indeed most likely the opposite)
- the likelihood that other insurers will follow the Bupa example?

### • **Data Protection**

Consultants should also know that Bupa does apparently hold information about them and that under the Data Protection Act they are entitled to see this. We would encourage all consultants to write to Bupa, who are obliged to respond even if they may ask for a very small fee not exceeding a few pounds. We attach a template letter that may be used to request this information.

### • **Patient Information Leaflet**

It is very important that consultants and hospitals should explain the issues to their Bupa patients. A Patient Information Leaflet has been prepared and is attached for you to download. This should be sent or given to patients and it will also be helpful to send this with a personal covering letter to your GP colleagues explaining the issues.

Patients who are affected by the removal of choice should be aware of the restrictions being placed upon them in terms of choice and benefits. As outlined in the Patient Leaflet they may take several steps.

- Patients can complain by writing to Bupa at <https://www.bupa.co.uk/contact> or by writing to the CEO of Bupa, Mr Stuart Fletcher, Chief Executive, Bupa, Bupa House, 15-19 Bloomsbury Way, London, WC1A 2BA and to Dr Natalie J Macdonald, Medical Director, Bupa Health & Wellbeing UK, Bupa, Willow House, Pinetrees, Staines, Middlesex TW18 3HZ
- All corporate subscribers to an “open referral” policy should explain to their HR director or their company manager responsible for their medical insurance that Bupa has removed their primary choice of consultant.
- Patients who remain dissatisfied or feel that their benefits have been reduced should report the issue to the Financial Services Ombudsman which is a free

service and information is available at <http://www.financial-ombudsman.org.uk/consumer/complaints.htm> The postal address is Financial Ombudsman Service, South Quay Plaza, 183 Marsh Wall, London E14 9SR. The Consumer Helpline is 0845 080 1800.

- Patients should note that there is a Private Patient Forum with a social network blog that they may wish to access and make their views known there. <http://www.privatepatientsforum.org/>

### **SUMMARY POINTS**

1. These are difficult times for all consultants and their patients. Consultants should appreciate the profound long term implications of the Bupa strategy; would it be a totally Managed Care scenario in which the insurer would control all aspects of patient care from preauthorisation of what treatment is allowable to the choice of consultant and the level of fees payable?
2. FIPO does not encourage unreasonable or excessive fees and also recommends that consultants should, whenever possible, give an estimate of fees in advance of treatment to their patients. Of course consultants who opt for a Bupa partnership will be reimbursed directly through the insurer at whatever level the insurer determines.
3. At the bottom line it is the patient who may suffer through lack of choice of consultant and if any consultant has evidence of patient diversion by an insurer resulting in an inappropriate specialist dealing with the case or if there has been any harm or delay to the patient then they should contact FIPO with the details. This will be dealt with in an anonymous manner.
4. You may wish to warn your referring GPs about this matter. Finally and most importantly, you may wish to share this letter with your local colleagues who may not have received this, bearing in mind that each consultant should make his/her personal decision about their intentions

about joining, remaining or leaving a “partnership” with an insurer.

**[TEMPLATE DATA PROTECTION LETTER FOR SUBJECT ACCESS REQUESTS]**

[Sender’s address]

[Date]

Head of Information Governance  
Bupa House  
15 – 19 Bloomsbury Way  
London WC1A 2BA

Dear Sir or Madam

**Data Protection Act 1998 – Request for information**

I, [INSERT FULL NAME], am a consultant registered with Bupa to provide services to persons insured by Bupa. [My Bupa registration number is: [INSERT REGISTRATION OR OTHER REFERENCE NUMBER, IF APPLICABLE].]

Under the Data Protection Act 1998 I am entitled to receive information that you hold about me. Please send me any information that relates to me and in particular any information relating to my ranking by Bupa against other consultants.

Furthermore, please can you send an explanation of the process involved in any automated decisions made about me.

If you require any further information, or if you charge an administrative fee to process this request, please let me know as soon as possible.

If you do not normally deal with these requests, please pass this letter to your Data Protection Officer or another appropriate officer.

Yours faithfully,

[INSERT FULL NAME]

**PATIENT INFORMATION LEAFLET FOR BUPA MEDICAL INSURANCE SUBSCRIBERS**

FIPO (Federation of Independent Practitioner Organisations) is a professional medical body representing consultants who work in the independent sector. All Bupa subscribers should

understand that Bupa, the private medical insurer, has recently altered the way in which it deals with certain subscribers when they seek consultant treatment.

## Recent Bupa Changes

- Cuts in reimbursements (benefits) for your consultants' fees
- Clinical decisions by Bupa about what is appropriate treatment
- "Open Referral" which removes choice of consultant from the patient

## Bupa Insurance Reimbursements for Consultant Fees

We regret that the benefits provided by Bupa medical insurance for a number of common causes of treatment and operations have been reduced across a number of medical specialties. The average cut back is nearly one third (32.25%), across 39 common operations, so far declared by Bupa. This means that patients will be reimbursed on average £213 less for each of these specified procedures.

Bupa have not raised their reimbursements for surgical procedures to patients for their consultants' fees since 1993 and so unfortunately the consultants may have no choice but to ask their patients for co-payment to cover these insurance cutbacks. In the spirit of promoting transparency of fees for medical treatment, which FIPO has historically promoted across all its member organisations and is keen to promote going forward, Bupa subscribers need to know that they may be faced personally with an increased need for co-payment to cover their consultants' fees.

## Bupa Clinical Decisions at Preauthorisation

Further, BUPA subscribers need to know that in some cases (for example if a consultant orthopaedic surgeon recommends an arthroscopic knee operation or a certain shoulder operation) Bupa will ask for clinical details from their consultant and then decide if they wish to fund the procedure or not. This may lead to Bupa not allowing any payment for the specific operation recommended by your specialist consultant.

## Bupa "Open Referral"

Bupa has adopted across a number of policies a so-called "open referral" strategy. If your insurance is under this new type of policy then at pre-authorisation (when you obtain insurance consent for treatment) Bupa may ask you to go and see a different consultant from the one whom you may wish to see and may provide you with other names. Your personal choice is normally based on your GP's recommendation or it may be based on your own research; in many cases it is because the consultant is someone whom you have seen previously. Therefore, you will have lost your primary choice of consultant and possibly of hospital. You may still receive appropriate treatment for your condition but not all consultants have the same specialist interests.

may still receive appropriate treatment for your condition but not all consultants have the same specialist interests.

## What Can Patients Do?

If you are not happy with these changes, there are some steps that you can take.

- Always insist on seeing your consultant of choice and always try and obtain an estimate of fees from the consultant's office before embarking on treatment. This will not be possible in an emergency situation.

- If you are a subscriber to a corporate medical insurance scheme whose policy prevents your choice of consultant (and not all do this) then you can bring this to the attention of the manager or HR director in your company who arranges your insurance. The changes to the policies and their impact will be taken into account by your company at the next policy renewal date.

- You may wish to register your complaint with Bupa, emailing Bupa at <https://www.bupa.co.uk/contact> or to by

writing to the CEO of Bupa, Mr Stuart Fletcher, Chief Executive, Bupa, Bupa House, 15-19 Bloomsbury Way, London, WC1A 2BA and to Dr Natalie J Macdonald, Medical Director, Bupa Health & Wellbeing UK, Bupa, Willow House, Pinetrees, Staines, Middlesex, TW18 3HZ. You may wish to copy us in on this complaint at FIPO.

Patients who remain dissatisfied can report the issue to the Financial Services Ombudsman. The ombudsman provides a

free and user friendly service. Information is available at <http://www.financial-ombudsman.org.uk/consumer/complaints.htm> The postal address is Financial Ombudsman Service, South Quay Plaza, 183 Marsh Wall, London E14 9SR. The Consumer Helpline is 0845 080 1800.

Patients should also note that there is a Private Patient Forum with a social network blog. You may wish to report your story there:

<http://www.privatepatientsforum.org/>

## **THE NON ARTHROPLASTY HIP REGISTER (NAHR)**

### **John Timperley**

A national register to collect data on the outcome of hip conditions not treated by arthroplasty went live in March at the 2012 British Hip Society Annual Meeting in Manchester. It will be formally launched at the British Orthopaedic Association Annual Congress in September 2012.

### **Formation of the Non Arthroplasty Hip Register (NAHR)**

The creation of a Non Arthroplasty Hip Register was unanimously supported by the Membership of the British Hip Society at the Annual General Meeting in Torquay (March 2011) and development of the Registry has been funded by the members of that Society (see: <http://britishhipociety.com/NAHR/Index.htm>).

### **Scope of the NAHR**

The NAHR has been set up to collect longitudinal outcome data for any type of hip condition and/or surgery other than arthroplasty and the treatment of acute fracture. It has been constructed so that paediatric conditions can also be studied for the lifetime of the patient.

Clinicians will be able to use the Register to collect and display comprehensive outcome and audit data for all of their own patients using scores and outcome measures of their own choice. Data can be entered for patients who do not undergo surgery for any specific condition so that their clinical course can be followed. Only one hip 'pathway' can be started for left or right hips in an individual so patients are not lost if they move between clinicians. If the patient has consented for their data to be collected only an arthroplasty or the

patient's demise will close the record.

The independence of the reporting of data remains critical to the credibility of the NAHR. The BHS will protect the confidentiality of the information contained in the NAHR and maintains high level data security procedures. No other clinician, including members of the NAHR Subcommittee, will be able to view an individual surgeon's data or outcomes. All data will be anonymised. A Policy document has already been agreed setting out who can request data of the Registry and how access to information can be requested.

NICE Interventional Procedure Guidance on Arthroscopic (IPG 408) and Open (IPG 403) Femoro-Acetabular Surgery for Hip Impingement Syndrome notes that clinicians should submit details to this national register. For the condition of femoro-acetabular impingement, clinicians may choose to facilitate only collection of an initial Minimum Data Set (as they do with the NJR) and leave the Registry to collect further outcome data but the functionality is there for the clinician to organise any outcome measure or clinical score he/she desires.

### **Who benefits from the creation of the NAHR?**

If we can define the indication for all types of non-arthroplasty hip surgery everyone benefits:

**The Patients.** Patients will only undergo surgery if it is likely to reduce their pain, improve their function (ability to undertake activity and work) and/or prevent the progress of arthritis of the hip and ultimately a hip replacement. Patients who will not benefit are spared the risk of surgery and the potential for the procedure to exacerbate their symptoms and

accelerate the progression of arthritis.

**The Purchasers of Healthcare.** Funding will be targeted on patients who will benefit from a surgical procedure. Funds will not be used where the outcome clearly does not justify the resource.

**Surgeons.** Surgeons will be able to define which patients will benefit from surgery and what details of the operative procedure will define a good result. The surgeon will have validated outcome data available to them.

**Orthopaedic Industry.** Annual reports in the public domain will give feedback to Industry about the number and nature of operations performed in the UK. Evidence will accumulate for which operations are proven to be beneficial and what details of the surgical procedure carry the highest probability for a good outcome (e.g. chondral treatment, method of labral repair, use of navigation etc.).

**The National Registries.** No other national registry is collecting this data and establishing this project will give us the only outcome data for these conditions in the world.

### **How it works**

Clinicians, whether members of the BHS or not, are able to Register to enter data via links on the BOA, BHS and NAHR websites (<http://britishhipsociety.com/NAHSR/Index.htm>).

### **Which patients should be entered?**

The NAHR has been set up to allow data collection for any patient with hip

conditions other than arthroplasty or fracture (e.g. trochanteric bursitis, iliopsoas impingement, SUFE, Perthes etc.).

The NAHR can track the outcome of conservative or surgical treatment for any hip condition.

NICE *requires* that data are entered onto the Registry for patients undergoing surgery for femoro-acetabular impingement (FAI) whether the surgery is open or arthroscopic.

### **Why enter data?**

For all conditions the surgeon can choose to enter as many scores and procedures as he/she wishes over any time interval. The NAHR will plot the results over time and display them graphically. The data on patients is confidential to the surgeon.

For patients with FAI, a system need to be put into place to collect pre-operative scores (EQ5-D, Modified HHS, UCLA activity) but the Registry can then collect outcomes automatically.

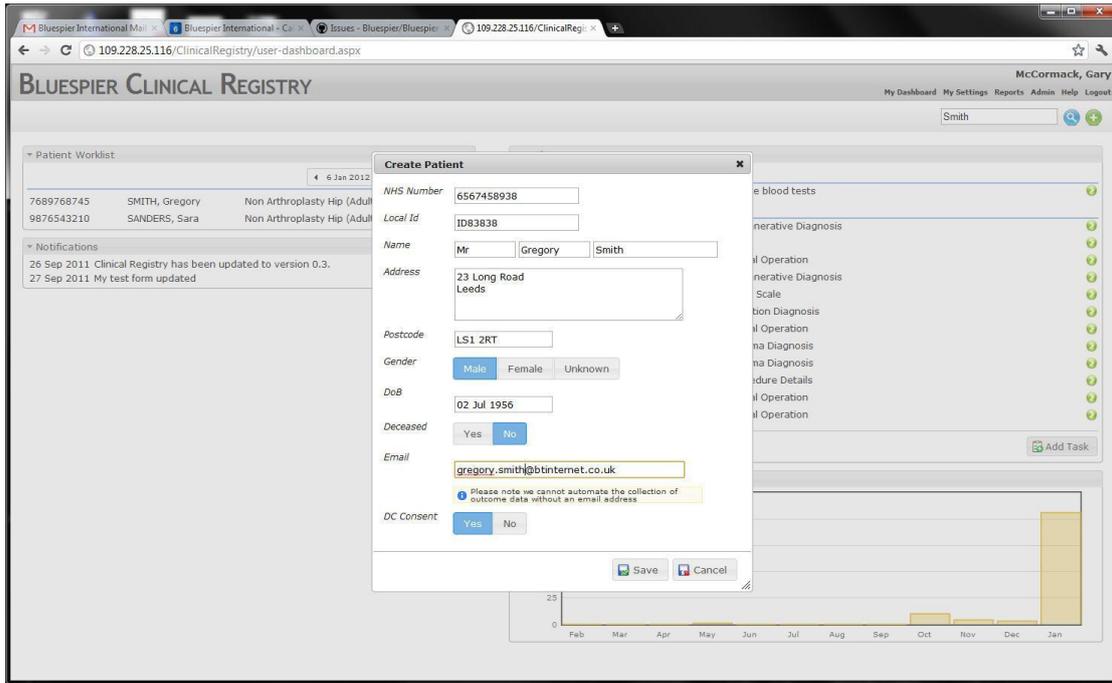
### **Getting started**

#### ***Patient Consent***

Is required

#### ***Initial registration of the patient***

Data can be entered directly on-line or collected on hard copy (downloaded from the NAHR website) and entered by a clerk later.



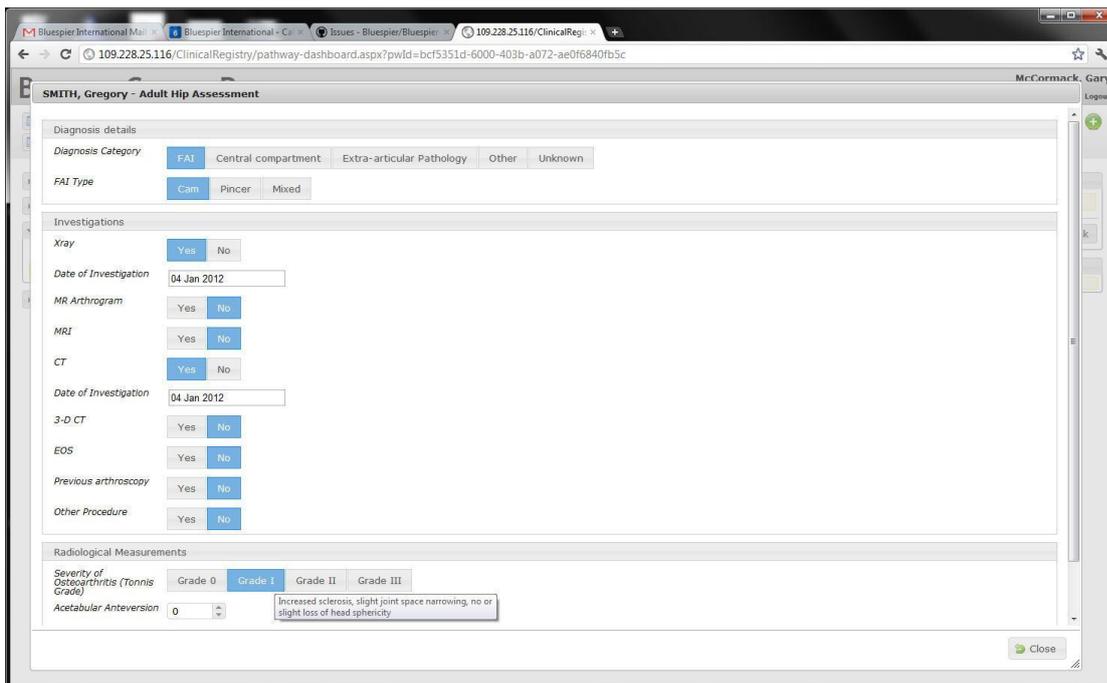
**Initial scores**

For conditions other than FAI the surgeon can choose to collect any number of scores from those available (see Minimum Data Set listed on NAHR website).

For cases of FAI the Minimum Data Set includes EQ 5-D, Modified Harris Hip Score and UCLA Activity.

**Operative details**

Operative details are recorded at the time of surgery and an operation note can be generated for the patient file.

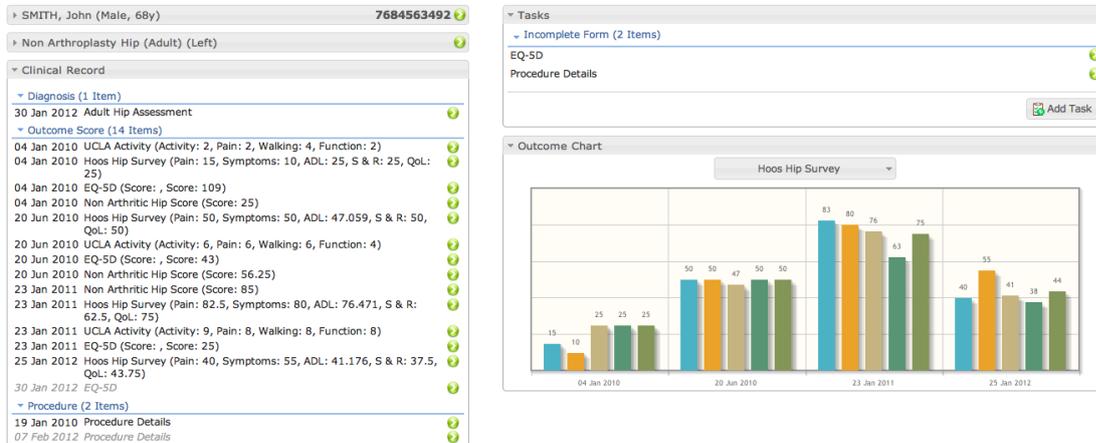


## Outcome data after surgery

For FAI patients, the NAHR is being constructed to collect longitudinal outcome

data automatically via e-mail.

Scores for individual patients are displayed graphically:



## What happens if a patient moves or the care is taken over by another surgeon?

Only one Pathway can be opened for each hip on a patient. If a surgeon tries to Register a patient where a Pathway has already been started he/she will be prompted to contact the previous surgeon through the Registry and allowed to add to the data pathway for that patient.

This is an exciting time for collection of data in the UK and the success of this venture will be to the benefit of all stakeholders.

**Please register for the BOA Annual Congress in September for the launch of NAHR:**



## Registry Sessions

**Thursday 13<sup>th</sup> September 2012**

**8.30am to 10.00am and 10.30 to 12.00, Exchange Auditorium**

**8.30 – 10.00 The New Culture of Data Collection in Orthopaedics**

Chair: John Timperley, Exeter

Non Arthroplasty Hip Register (NAHR)

British Spine Register (BASS)

PROMS 2

Knee ligament Register

National Hip Fracture Database (NHFD)

National Joint Register (NJR)

My Clinical Outcomes

9.30-9.45

***Registers: an overview from NICE***

Professor Bruce Campbell, MS, FRCP, FRCS,

Chairman Interventional Procedures Advisory Committee

National Institute for Health and Clinical Excellence

9.45-10.00

Discussion

10.00-10.30

Coffee

**10.30-12.00 NJR 9<sup>th</sup> Annual Report Highlights and Discussion**

Chair: Martyn Porter, Wrightington

10.30-10.40 Introduction

Laurel Powers-Freeling, London

10.40 – 10.50 2011 Trends

Peter Howard, Derby

10.50 – 11.00 Implant Issues

Keith Tucker, Norwich

11.00 – 11.10 What's new in knees?

Colin Esler, Leicester

11.10 – 11.20 Clinical Evidence

Ashley Blom, Bristol

11.20 – 11.30 Research Activity

Alex Macgregor, London

11.30 – 11.40 Patient perspective

Mary Cowern, Cardiff

11.40 – 12.00

Discussion

