Commissioning guide:

Pain arising from the hip in adults

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

Date of evidence search: Autumn 2012
Date of publication: November 2013
Date of Review: November 2016

NICE has accredited the process used by Surgical Speciality Associations and Royal College of Surgeons to produce its Commissioning guidance. Accreditation is valid for 5 years from September 2012. More information on accreditation can be viewed at www.nice.org.uk/accreditation
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The Royal College of Surgeons of England, 35-43 Lincoln’s Inn Fields, London WC2A 3PE
Introduction

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

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

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

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

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

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

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

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

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

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

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

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

The outcome of THR is better when well tried (e.g. ODEP 10A rated implants) are used, particularly when performed by experienced surgeons (for example those doing more than 70 per annum).
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Complex cases and younger patients with arthritis due to childhood hip disorders should be performed in centres performing high volumes of these cases.

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

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

1.1 Primary Care

Assessment:

- history - pain in the groin, medial thigh and greater trochanter radiating to thigh and knee at rest and/or after activity or isolated knee pain condition having an impact on occupation, daily activity and sports (e.g. decrease in walking distance, disability in negotiating stairs and performing pedicure)
- isolated pain over the greater trochanter settles in 64% of patients after one year and 71% after five years

- examination - examine the hip for tenderness and irritability on movement.
- investigations: a plain A-P radiograph of the pelvis may be requested to confirm the diagnosis after history and examination
- no further imaging (e.g. MRI or bone scan) is appropriate before referral

Emergency referral to secondary care

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

Immediate referral to secondary care

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

Management - offer to all people

Mild symptoms

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

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

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

1.2 Intermediate Care

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

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

---

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

Non-operative interventions if not already offered

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

Provision of appropriate aids if not already used

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

Referral to secondary care

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

1.3 Secondary Care

Assessment

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

Management

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

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

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

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

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

Total hip replacement

After appropriate diagnosis, consider **total hip replacement** when:\n
- pain is inadequately controlled by medication
- there is restriction of function
- the quality of life is significantly compromised
- there is narrowing of the joint space on radiograph

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

- The surgeon’s choice of technique, implant and bearing surface used should take into account the most recent evidence from the NJR.

- Enhanced Recovery protocols should be followed in the perioperative period including an individual needs based assessment prior to discharge. Service managers should ensure that there are support services to allow enhanced recovery.

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

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

Follow up visits

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

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

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

Routine follow up in General Practice is not advised.
Secondary Care

Surgery for hip impingement may be considered where there is diagnosis of hip impingement and failure of non-operative management.  

Femoral/pelvic osteotomy may be considered in:

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

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

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

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

2 Procedures explorer for pain arising from the hip in adults

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

The Procedures Explorer Tool is available via the Royal College of Surgeons website.
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replacement with or
Total prosthetic replacement of the hip, with
or without cement, bilateral  All above codes with Z941
As in primary hip replacement with code Z941 for bilateral operations
Complex primary total hip replacement (including bone grafting or femoral osteotomy)  W3713
Hip resurfacing arthroplasty  W3715
W581 with Z843
Hip resurfacing arthroplasty bilateral  W3719
W581 with Z843 and Z941

3 Quality dashboard for pain arising from the hip in adults

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

The quality dashboard is available via the Royal College of Surgeons website.

For current dashboard indicators (see appendix 1)

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

**Areas for development of dashboard**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Evidence Base</th>
<th>Data Source*</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROM (OHS) change at 6 months post-surgery for total hip replacement (THR) (and increased time periods as they become available)</td>
<td>National data set</td>
<td>The Health and Social Care Information Centre</td>
</tr>
<tr>
<td>Enhanced recovery programme for THR</td>
<td>HES data set</td>
<td>HES</td>
</tr>
<tr>
<td>Rate of blood transfusion in THR</td>
<td>BOA Guidance on Blood-transfusion in orthopaedic surgery</td>
<td>Trusts</td>
</tr>
<tr>
<td>Infection rate (THR)</td>
<td>HES data set</td>
<td>HES</td>
</tr>
<tr>
<td>Risk assessment for thromboprophylaxis with THR</td>
<td>NICE</td>
<td>Trusts</td>
</tr>
<tr>
<td>Implant dislocation rates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of cemented implants in % patients over 70 years having cemented implant</td>
<td>% patients over 70 years having cemented implant</td>
<td>NJR, HES</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>patients over 70 years</th>
<th>Reduces rate of revision and cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peri-prosthetic fractures&lt;sup&gt;39&lt;/sup&gt;</td>
<td>HES</td>
</tr>
<tr>
<td>Rate of Revision</td>
<td>NJR</td>
</tr>
<tr>
<td>Proportion achieving Best Practice Tariff (2014)&lt;sup&gt;3&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Completion of minimum dataset for non arthroplasty surgical operations in Non Arthroplasty Hip Register (NAHR)</td>
<td>NAHR</td>
</tr>
</tbody>
</table>

* includes data from HES, National Clinical Audits, Registries

4 Levers for implementation

4.1 Audit and peer review measures

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

<table>
<thead>
<tr>
<th>Measure</th>
<th>Standard</th>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence to NICE Guidance for referral</td>
<td>Percentage of people referred to secondary care for whom core treatments options attempted</td>
<td>Local use of referral checklist/tool Audit Peer review through GP Quality Outcomes Framework QP indicators</td>
</tr>
<tr>
<td>Patient Decision Aids</td>
<td>Number of patients confirming awareness / use of NHS Direct Patient Decision Aid</td>
<td></td>
</tr>
<tr>
<td>Change in PROM score for THR</td>
<td>A centre should demonstrate improved PROM outcome</td>
<td>National PROMs data</td>
</tr>
<tr>
<td>Enhanced Recovery</td>
<td>Number of patients cared for along</td>
<td>Performance on National ER</td>
</tr>
</tbody>
</table>

<sup>3</sup> The proposed changes to the best practice tariff for 2014/15 were not confirmed at the time of finalising the documents.
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<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Data specification (if required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preoperative assessment clinic.</td>
<td>Reduces late cancellation</td>
<td>Provider</td>
</tr>
<tr>
<td>24 hour telephone availability of a member of the arthroplasty team</td>
<td>Avoids inappropriate treatment by community services, reduced late cancellation</td>
<td>% &gt; 24 hour delay in treatment of complication</td>
</tr>
<tr>
<td>Routine follow up by Arthroplasty Care Practitioners and/or using telephone PROMs and community radiography to minimize trips to hospital</td>
<td>Improves follow up of patients at risk, frees time in outpatient clinics to assess new patients Makes follow up less of a burden to patients</td>
<td>% patients &gt;75 years, &lt;65 years followed up in hospital clinic Alternative clinics</td>
</tr>
<tr>
<td>Target length of stay (LoS) should be 3-4 days</td>
<td>Encourages early supported discharge</td>
<td>% patients with LoS &gt; 4 days</td>
</tr>
<tr>
<td>Proportion achieving Best Practice Tariff [2014]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients entered onto NJR</td>
<td>Improves data quality</td>
<td>&gt;90%</td>
</tr>
</tbody>
</table>
5 Directory

5.1 Patient Information for pain arising from the hip in adults

<table>
<thead>
<tr>
<th>Name</th>
<th>Publisher</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip replacement</td>
<td>NHS Choices</td>
<td><a href="http://www.nhschoices.nhs.uk">www.nhschoices.nhs.uk</a></td>
</tr>
<tr>
<td>Hip joint replacements</td>
<td>EMIS</td>
<td><a href="http://www.patient.co.uk">www.patient.co.uk</a></td>
</tr>
<tr>
<td>Hip OA decision aid</td>
<td>Right Care</td>
<td><a href="http://sdm.rightcare.nhs.uk/pda/osteoarthritis-of-the-hip">http://sdm.rightcare.nhs.uk/pda/osteoarthritis-of-the-hip</a></td>
</tr>
<tr>
<td>NHS Evidence</td>
<td>NHS</td>
<td><a href="http://www.evidence.nhs.uk">www.evidence.nhs.uk</a></td>
</tr>
<tr>
<td>NICE OA Guideline</td>
<td></td>
<td><a href="http://guidance.nice.org.uk/CG/Wave0/685">http://guidance.nice.org.uk/CG/Wave0/685</a></td>
</tr>
</tbody>
</table>

5.2 Clinician information for pain arising from the hip in adults

<table>
<thead>
<tr>
<th>Name</th>
<th>Publisher</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip disease replacement prostheses</td>
<td>NICE</td>
<td><a href="http://www.nice.org.uk">www.nice.org.uk</a></td>
</tr>
<tr>
<td>Hip osteoarthritis</td>
<td>NHS Clinical Knowledge Summaries</td>
<td><a href="http://www.cks.nhs.uk">www.cks.nhs.uk</a></td>
</tr>
<tr>
<td>Hip pain</td>
<td>Map of Medicine</td>
<td>healthguides.mapofmedicine.com</td>
</tr>
</tbody>
</table>

6 Benefits and risks

Benefits and risks of commissioning the pathway are described below.

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

7  Further information

7.1  Research recommendations

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

7.2  Other recommendations

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


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

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

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

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

7.5 Funding statement

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

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

7.6 Methods Statement

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

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

Appendix 1: Dashboard

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

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

http://rcs.methods.co.uk/dashboards.html
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Methods Insight Analytics in association with BOA
Rightcare Surgical Commissioning Dashboard: Orthopaedics

The Right Care Dashboard provides rates of Activity for CCGs for interventions identified as a priority by the surgical specialist association. These rates are directly standardised against the national population for Age and Sex.

This dashboard supports the Painful Deep Pain treatment of the Hip commissioning guidance document developed by the BOA working group with the RCSE.

Report Overview

<table>
<thead>
<tr>
<th>Intervention Name</th>
<th>Indicator name</th>
<th>Period</th>
<th>Value</th>
<th>National Mean</th>
<th>Chart</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip resurfacing</td>
<td>Activity rate per 100,000 population (DHS)</td>
<td>FY 2012/13</td>
<td>0.34</td>
<td>0.34</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Average length of stay (hours)</td>
<td>FY 2012/13</td>
<td>3.0</td>
<td>3.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 Day Hospitalisation rate (%)</td>
<td>FY 2012/13</td>
<td>0.06%</td>
<td>0.06%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 Day re-admission rate (%)</td>
<td>FY 2012/13</td>
<td>0.06%</td>
<td>0.06%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Re-admission within 90 days (%)</td>
<td>FY 2012/13</td>
<td>0.06%</td>
<td>0.06%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Day case rate (%)</td>
<td>FY 2012/13</td>
<td>0.06%</td>
<td>0.06%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In-hospital Mortality rate (per 1,000 provider-population)</td>
<td>FY 2012/13</td>
<td>0.06</td>
<td>0.06</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Where data is available indicators will have a ‘sparkline’ showing the previous 8 data points. These are a condensed way to show variation and trend. The volume of change is not represented on this dashboard and the sparkline should be used to interpret directional change only.

How to interpret charts

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

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

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

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

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

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

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

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

** These charts are constructed using statistical process control (SPC) principles and use control limits to indicate variation from the national mean. The display shows both two standard deviation (95%) control limits and three standard deviation (99.73%) control limits. Values within these limits (the light grey sections) are said to display “normal cause variation” in that variation from the mean can be considered to be random. Values outside these limits (in the light green or orange sections) are said to display “special cause variation” at a two standard deviation level, and a cause other than random chance should be considered. Values outside these sections (in the dark green or red sections) also display “special cause variation” but against a more stringent test.

Variation at the two standard deviation level can be considered to raise an alert, and variation at the three standard deviation level to raise an alarm.
# Commissioning guide 2013

**Pain arising from the hip in adults**

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**Example CCG**

## Orthopaedics—Painful Osteoarthritis of the Hip

### Total Hip replacement (Unilateral)

<table>
<thead>
<tr>
<th>Metric</th>
<th>Period</th>
<th>Value</th>
<th>Mean</th>
<th>Chart</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daycase Rate (%)</td>
<td>RY Q4 12/13</td>
<td>0.00</td>
<td>0.15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Hospital Mortality Rate (per 1,000 discharges)</td>
<td>RY Q4 12/13</td>
<td>0.00</td>
<td>0.73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age/Sex Standardised Activity (per 100,000 population)</td>
<td>RY Q4 12/13</td>
<td>63.65</td>
<td>100.64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Length of Stay (Days)</td>
<td>RY Q4 12/13</td>
<td>4.11</td>
<td>4.96</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Day Readmission Rate (%)</td>
<td>RY Q4 12/13</td>
<td>4.44</td>
<td>1.84</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Day Readmission Rate (%)</td>
<td>RY Q4 12/13</td>
<td>7.78</td>
<td>5.17</td>
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</tr>
<tr>
<td>30 Day Resperation Rate (%)</td>
<td>RY Q4 12/13</td>
<td>3.53</td>
<td>3.73</td>
<td></td>
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</tr>
</tbody>
</table>

### Trend

- **Chart**
  - Lower 3SD
  - Lower 2SD
  - Upper 2SD
  - Upper 3SD
  - Organisational Value
  - National Mean

- **Trend**
  - Upper 3SD
  - National Mean
  - Organisation Value
  - Lower 3SD

---

## Hip resurfacing

<table>
<thead>
<tr>
<th>Metric</th>
<th>Period</th>
<th>Value</th>
<th>Mean</th>
<th>Chart</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age/Sex Standardised Activity (per 100,000 population)</td>
<td>RY Q4 12/13</td>
<td>0.94</td>
<td>3.02</td>
<td></td>
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<tr>
<td>Average Length of Stay (Days)</td>
<td>RY Q4 12/13</td>
<td>3.00</td>
<td>3.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Day Readmission Rate (%)</td>
<td>RY Q4 12/13</td>
<td>0.00</td>
<td>0.22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Day Readmission Rate (%)</td>
<td>RY Q4 12/13</td>
<td>0.00</td>
<td>0.67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50 Day Readmission Rate (%)</td>
<td>RY Q4 12/13</td>
<td>0.00</td>
<td>0.22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daycase Rate (%)</td>
<td>RY Q4 12/13</td>
<td>0.00</td>
<td>0.67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Hospital Mortality Rate (per 100,000 discharges)</td>
<td>RY Q4 12/13</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Total Hip replacement (Bilateral)

<table>
<thead>
<tr>
<th>Metric</th>
<th>Period</th>
<th>Value</th>
<th>Mean</th>
<th>Chart</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age/sex Standardised Activity (per 100,000 population)</td>
<td>RY Q4 1213</td>
<td>1.54</td>
<td>1.29</td>
<td>![Chart Image]</td>
<td>![Trend Image]</td>
</tr>
<tr>
<td>Average Length of Stay (Days)</td>
<td>RY Q4 1213</td>
<td>12.50</td>
<td>8.59</td>
<td>![Chart Image]</td>
<td>![Trend Image]</td>
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<tr>
<td>7 Day Readmission Rate (%)</td>
<td>RY Q4 1213</td>
<td>0.00</td>
<td>0.30</td>
<td>![Chart Image]</td>
<td>![Trend Image]</td>
</tr>
<tr>
<td>30 Day Readmission Rate (%)</td>
<td>RY Q4 1213</td>
<td>0.00</td>
<td>0.00</td>
<td>![Chart Image]</td>
<td>![Trend Image]</td>
</tr>
<tr>
<td>30 Day Reoperation Rate (%)</td>
<td>RY Q4 1213</td>
<td>0.00</td>
<td>0.30</td>
<td>![Chart Image]</td>
<td>![Trend Image]</td>
</tr>
<tr>
<td>Daycase Rate (%)</td>
<td>RY Q4 1213</td>
<td>0.00</td>
<td>0.30</td>
<td>![Chart Image]</td>
<td>![Trend Image]</td>
</tr>
<tr>
<td>In Hospital Mortality Rate (per 1,000 discharges)</td>
<td>RY Q4 1213</td>
<td>0.00</td>
<td>12.61</td>
<td>![Chart Image]</td>
<td>![Trend Image]</td>
</tr>
</tbody>
</table>