Northumbria Hip Preservation Unit
Patient Reported Outcomes

PLEASE RETURN THIS FORM TO: CLINICAL OUTCOMES OFFICE
HEXHAM GENERAL HOSPITAL, CORBRIDGE ROAD, HEXHAM NE46 1QJ

PATIENT ID LABEL:

PROMs

NAHS2

As part of our on-going commitment to our patients we may ask you to complete a PROMs questionnaire at different stages of your treatment. The information you provide in these questionnaires will be used by healthcare professionals within Northumbria Healthcare NHS Foundation Trust that have been involved in your care. This is to monitor your health and the success of your treatment. From the information collected on these questionnaires, anonymised data will be used for the purposes of service improvement, planning and research. We believe that the information collected is important in enabling us to carry out the most effective and high quality care possible and that it is in the public interest that we do so. We recommend that all patients take part, where possible. All information collected as part of this process is stored securely in line with our standard policies.

It is important to note however that participation is not compulsory and should you choose not to take part this will not affect your care in any way.

At any point you can inform us that you no longer wish to participate and we will no longer provide you with any questionnaires in the future.

For further information on how we use your information and your rights under Data Protections laws, please see our full Privacy notice at www.northumbria.nhs.uk or ask a member of staff.

INSTRUCTIONS: Please complete *ALL* of the questions with ONE ANSWER ONLY.
Scores may not be able to be calculated if any questions are left blank or more than one answer is selected.
If you are unsure, please choose the answer which seems closest.
If you do not do an activity, please choose the answer you think would apply if you *DID*.

TODAY'S DATE:_____ CONSULTANT'S NAME:_____

ON WHICH HIP DID YOU HAVE THIS PROCEDURE? ☐ Left ☐ Right

Please answer the questions on both sides of the paper

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Patient Information Questionnaire

We now have a system which allows you to complete future PROMs questionnaires online if preferred. These are sent at approximately 6-months, 1-year and 2-years after your surgery, and may continue annually for certain operations. (e.g. PAO)

If you would like us to send you a link to complete your answers online please give us your details below. You may select more than one if wanted. If you choose neither, we will post a paper form to your home as normal.

E-mail link to online questionnaire ☐ **SMS** link to online questionnaire ☐

E-mail address (CAPITAL LETTERS for clarity) _____

Mobile phone number _____

Q1. Do you smoke?

☐ Never smoked ☐ Current smoker ☐ Ex-smoker

Q2. Do you vape or use an E-Cigarette (include all types of tobacco) ?

☐ Never ☐ Current vaper/e-cig user ☐ Former vaper/e-cig user

Q3. Please tell us your height and weight:

What is your height? You can use imperial (ft. & in.) or metric (cm).

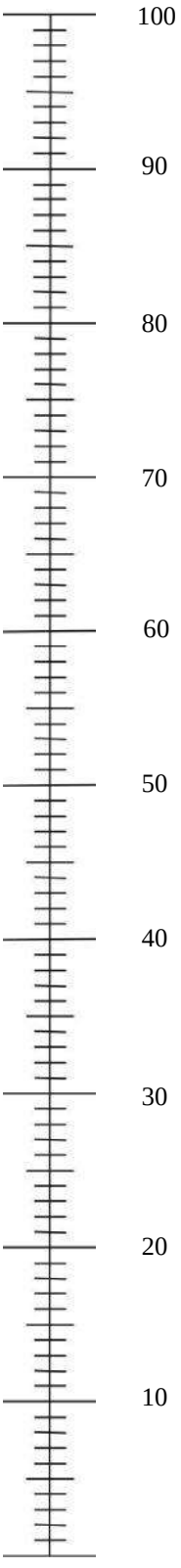
Height _____ Feet and inches ☐ Centimetres ☐

What is your weight? You can use imperial (st. & lbs.) or metric (kg).

Weight _____ Stones and pounds ☐ Kilogrammes ☐

- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine. 0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY
- Now, please write the number you marked on the scale in the box below

YOUR HEALTH TODAY = ☐



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This section asks about you and your health in general.

Under each heading, please tick the ONE box that best describes your health TODAY

1. Mobility
☐ I have no problems in walking about
☐ I have slight problems in walking about
☐ I have moderate problems in walking about
☐ I have severe problems in walking about
☐ I am unable to walk about
2. Self- care (i.e. washing and dressing)
☐ I have no problems washing or dressing myself
☐ I have slight problems washing or dressing myself
☐ I have moderate problems washing or dressing myself
☐ I have severe problems washing or dressing myself
☐ I am unable to wash or dress myself
3. Usual activities (i.e. work, study, housework, family or leisure activities)
☐ I have no problems doing my usual activities
☐ I have slight problems doing my usual activities
☐ I have moderate problems doing my usual activities
☐ I have severe problems doing my usual activities
☐ I am unable to do my usual activities
4. Pain/Discomfort
☐ I have no pain or discomfort
☐ I have slight pain or discomfort
☐ I have moderate pain or discomfort
☐ I have severe pain or discomfort
☐ I have extreme pain or discomfort
5. Anxiety/Depression
☐ I am not anxious or depressed
☐ I am slightly anxious or depressed
☐ I am moderately anxious or depressed
☐ I am severely anxious or depressed
☐ I am extremely anxious or depressed

OFFICE USE ONLY	**EQ-5D 5L Index (TTO) score:**

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The remaining questions ask for your views about your hip

Your current activity level

Please tick the box nearest the number that best describes your current level of activity.

☐	**1: Wholly Inactive, dependent on others, and cannot leave residence**
☐	**2: Mostly Inactive or restricted to minimum activities of daily living**
☐	**3: Sometimes participates in mild activities, such as walking, limited housework and limited shopping**
☐	**4: Regularly Participates in mild activities**
☐	**5: Sometimes participates in moderate activities such as swimming or could do unlimited housework or shopping**
☐	**6: Regularly participates in moderate activities**
☐	**7: Regularly participates in active events such as bicycling**
☐	**8: Regularly participates in active events, such as golf or bowling**
☐	**9: Sometimes participates in impact sports such as jogging, tennis, skiing, acrobatics, ballet, heavy labor or backpacking**
☐	**10: Regularly participates in impact sports**

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Non-Arthritic Hip Score

For each situation, please tick the response that most accurately reflects the situation in the **past 48 hours.**

ABOUT YOUR PAIN:	**None**	**Mild**	**Moderate**	**Severe**	**Extreme**
P1. Amount of pain walking on a flat surface	☐	☐	☐	☐	☐
P2. Amount of pain going up or down stairs	☐	☐	☐	☐	☐
P3. Amount of pain in bed at night	☐	☐	☐	☐	☐
P4. Amount of pain when sitting or lying	☐	☐	☐	☐	☐
P5. Amount of pain when standing upright	☐	☐	☐	☐	☐
ABOUT YOUR SYMPTOMS:	None	Mild	Moderate	Severe	Extreme
S1. Amount of trouble with catching or locking of hip	☐	☐	☐	☐	☐
S2. Amount of trouble with hip giving out on you	☐	☐	☐	☐	☐
S3. Amount of trouble with stiffness in your hip	☐	☐	☐	☐	☐
S4. Amount of trouble with decreased motion in your hip	☐	☐	☐	☐	☐
ABOUT YOUR FUNCTION:	None	Mild	Moderate	Severe	Extreme
D1. Degree of difficulty when descending stairs	☐	☐	☐	☐	☐
D2. Degree of difficulty when ascending stairs	☐	☐	☐	☐	☐
D3. Degree of difficulty when rising from sitting	☐	☐	☐	☐	☐
D4. Degree of difficulty when putting on socks/stockings	☐	☐	☐	☐	☐
D5. Degree of difficulty when rising from bed	☐	☐	☐	☐	☐
ABOUT YOUR ACTIVITY:	None	Mild	Moderate	Severe	Extreme
A1. Amount of trouble participating in high demand sports involving sprinting or cutting **(for example, football, basketball, tennis, and exercise aerobics)**	☐	☐	☐	☐	☐
A2. Amount of trouble participating in low demand sports (for example, golfing and bowling)	☐	☐	☐	☐	☐
A3. Amount of trouble jogging for exercise	☐	☐	☐	☐	☐
A4. Amount of trouble walking for exercise	☐	☐	☐	☐	☐
A5. Amount of trouble with heavy household duties **(for example, lifting firewood and moving furniture)**	☐	☐	☐	☐	☐
A6. Amount of trouble with light household duties **(for example, cooking, dusting, vacuuming, and doing laundry)**	☐	☐	☐	☐	☐

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iHOT-12

Please mark a point along the line that most appropriately represents the level of your typical situation in the last month.
If you don't do an activity, imagine how your hip would feel if you had to try it.

1. Over all how much pain do you have in your hip or groin?

Extreme pain — No pain at all

2. How difficult is it for you to get up and down off the floor/ground?

Extreme difficulty — No difficulty at all

3. How difficult is it for you to walk long distances?

Extreme difficulty — No difficulty at all

4. How much trouble do you have with grinding, catching or clicking in your hip?

Severe trouble — No trouble at all

5. How much trouble do you have pushing, pulling, lifting or carrying heavy objects at work?

Severe trouble — No trouble at all

6. How concerned are you about cutting/changing directions during your sporting or recreational activities?

Extreme concern — No concern at all

7. How much pain do you experience in your hip after activity?

Extreme pain — No pain at all

8. How concerned are you about picking up or carrying children because of your hip?

Extreme concern — No concern at all

9. How much trouble do you have with sexual activity because of your hip? Or N/A

Extreme trouble — No trouble at all

10. How much of the time are you aware of the disability in your hip?

Constantly aware — Not aware at all

11. How concerned are you about your ability to maintain your desired fitness level?

Extreme concern — No concern at all

12. How much of a distraction is your hip problem?

Extremely distracted — Not distracted at all

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Complications

After your last hip operation did you suffer with a clot in the leg (venous thrombosis) or clot in the lung (pulmonary embolus) diagnosed within 3 months of the operation?

Venous thrombosis (clot in the leg) ☐ **Yes** ☐ **No**

Pulmonary embolus (clot in lung) ☐ **Yes** ☐ **No**

Have you had any other operations on your hip since? ☐ **Yes** ☐ **No**

Any other information about your hip surgery you think might be useful? Please give details if yes. ☐ **Yes** ☐ **No**

Final part: Post operative Questionnaire

Q1a. Have you returned to work after your surgery?

☐ **I am not working – I did not work prior to surgery for other reasons**

☐ **I am not working - I did not work prior to surgery because of the problem for which I had surgery**

☐ **I am planning to return to work once I feel able or once my consultant allows me**

☐ **I have returned to work**

☐ **I am retired**

Q1b. For how many weeks were you off work because of the problem for which you had surgery (leave blank if not applicable)? _____ Weeks

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Q2. How satisfied are you with the outcome of this operation?

☐ Very satisfied ☺☺ ☐ Quite satisfied ☺ ☐ Neither satisfied nor dissatisfied 😐 ☐ Quite dissatisfied ☹ ☐ Very dissatisfied ☹☹

Q3. How likely are you to recommend the <u>hospital</u> to friends/family if they required similar care/treatment?

☐ **Extremely likely** ☐ **Likely** ☐ **Neither likely nor unlikely** ☐ **Unlikely** ☐ **Don't know**

Q4. How likely are you to recommend the <u>consultant</u> to friends/family if they required similar care/treatment?

☐ **Extremely likely** ☐ **Likely** ☐ **Neither likely nor unlikely** ☐ **Unlikely** ☐ **Don't know**

Any additional comments or feedback?

General comments will be collated and passed on to your consultant and/or team as appropriate.

If you have any specific concerns or questions, please contact your consultant's secretary for clinical advice or follow up.