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Supplementary Material

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Table i. Summary of evidence for Delphi study. The authors turned this into a short evidence briefing document for the participants' introduction.

#	Piece of work	Synopsis
1	WS1 (qualitative) NON-STOP, 2023[1]	- Clinicians and child/family dyads* mention need for consistent evidence. - Long- and short-term goals discussed, i.e. radiological outcome at skeletal maturity and function (i.e. pain, activity levels). - App well received as a concept by clinicians and child/family dyads. - App could provide a step towards consensus/agreement on treatment and a reduction in variation of care.
2	Systematic review, 2020[2]	- No evidence regarding most effective NON-STOP. - Brech and Guarnieiro[3] showed improvement in range of motion (ROM) and strength compared with no intervention. - Inconsistent findings of orthotics versus no intervention (similar results) or surgery (varied for and against). - > 12 years old did worse with 'minimal' (crutches) input compared to orthotics and surgery. - Larger proportion of children had better Stulberg after having an intervention that wasn't 'watchful waiting' or no intervention.
3	Case review, 2020[4]	- Demonstrates a variation of care in centres around the UK. - Some children are advised to limit activity while some are not. Similar advice varies for pain relief and physiotherapy referral.
4	BOSS, 2022[5]	- Incidence rate in UK is 2.48/100,000. - Stiffness is biggest predictor of surgery, age of > 8 years next most important predictor. - Despite frequency of containment surgery, no evidence of improved outcomes (PROMs (PedsQL), Stulberg). - Need a RCT (but no consensus on NON-STOP)
5	Herring et al, 2004[6]	- No significant difference in the surgical or non-surgical treatment approaches. - Children aged ≤ 6 years were not differently impacted by any intervention and did as well with NON-STOP. - Children aged > 8 years did better with surgery than non-surgery.

		- Lateral pillar classification and age at onset were strong prognostic factors. If a child was lateral pillar C, their outcomes were poor irrespective of intervention. Group B or B/C border did better with surgery if over 8 years old compared with NON-STOP. - Girls did worse if > 8 years old.
6	Wiig et al, 2008[7]	- Head involvement (%) best predictor, followed by age at diagnosis and lateral pillar classification. - In children > 6 years old with > 50% femoral head involvement, surgery gave better outcome than physio or orthosis. - Physio in those < 6 years old had a favourable outcome (as did orthosis and surgery). - Concluded with suggestion of surgery for > 6 years old children at diagnosis and > 50% femoral head involvement, and that abduction orthosis should be abandoned.
7	Core outcome set, 2020[8]	- Delphi study for COS (from systematic review and qualitative study). - 16 outcomes identified; six categories (adverse events, life impact, resource use, pathophysiological manifestations, death, and technical considerations). - PROMIS (separate study)[9] showed construct validity, supporting its use in the population.

*Dyad refers to 'pairs', i.e. one child and one family member = one child/family dyad.
BOSS, British Orthopaedic Surveillance Study; COS, core outcome set; PROM, patient-reported outcome measure; RCT, randomized controlled trial.

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