National Clinical Guideline Centre for Acute and Chronic Conditions

HIP FRACTURE GUIDELINE

3rd Guideline Development Group Meeting

Tuesday 15th September 2009, 10.30am – 4.00pm
NCGC Office Euston Road, London

Minutes of the meeting

Present:

GDG members: Professor Cameron Swift (CGS), Dr Antony Johansen (AJ), Mr Tim Chesser (TC), Mr Bob Handley (BH), Ms Karen Hertz (KH), Mrs Heather Towndrow (HT), Ms Tessa Somerville (TS), Mr Anthony Field (AF), Mr Martin Wiese (MW), Professor Sallie Lamb (SL), Mr Tim Chesser (TC) and Professor Opinder Sahota (OS).

NCGC Saoussen Ftouh (SF), Elisabetta Fenu (EF), Carlos Sharpin (CS), Joanna Ashe (JA), Sarah Riley (SR), Maggie Westby (MJW)

Apologies: Dr Sally Hope (SH), Dr Richard Griffiths (RG).

Agenda Item	Discussion/Outcome
1. Introductions and apologies for absence, minutes of the last meeting and declaration of interests	CGS welcomed everyone to the 3rd Hip Fracture GDG meeting. Apologies: CGS noted apologies from SH and RG. Minutes: The minutes of the last meeting were agreed as being accurate. Declarations of interest (DOI): There were no changes in GDG members and NCGC staff's DOIs since the last meeting. No actions were taken following these declarations and none of the GDG members needed to withdraw from discussions as a result of conflicting interests.
2. The Hip Fracture guideline (Prof. Cameron Swift)	CS gave an overview of the scope of the hip fracture guideline with particular emphasis on the rehabilitation sections as these will be among the main aspects which distinguish this guideline from other previously published hip fracture guidelines.
3. Structure of the Hip Fracture guideline (Jenny Hill)	JH gave a presentation on the proposed structure of the guideline write up and showed an example of one of the guidelines that had recently been

Agenda Item	Discussion/Outcome
	submitted by the centre. She explained how the GDG should go about linking the evidence to the recommendations (LETR).
4. Types of hip fractures and hip fracture repair implants (Tim Chesser and Bob Handley)	TC and BH gave introductory presentations on the different types of proximal femoral fractures and the implants used to repair them.
5. Choice of surgical implants - Sliding hip screw versus intramedullary nails for trochanteric and subtrochanteric extracapsular fractures.	SR presented the clinical evidence on sliding hip screw versus intramedullary nails for trochanteric and subtrochanteric extracapsular fractures. EF subsequently presented the economic evidence relating to this question. This was followed by a general discussion by the GDG to try and formulate a recommendation based on this evidence. MJW suggested that SR should carry out further analyses to try to find out the reasons for heterogeneity. **Action:** **TC and BH to complete the LETR table and related sections in the chapter write up in collaboration with the technical team.** **SR to look into the reasons for heterogeneity.**
6. Cemented versus non-cemented arthroplasty implants.	CS presented the clinical evidence on cemented versus non-cemented arthroplasty implants and EF presented the economic evidence relating to this question. This was followed by a general discussion by the GDG to try and formulate a recommendation based on this evidence. **Action:** **TC and BH to complete the LETR table and related sections in the chapter write up in collaboration with the technical team.**
7. Discussion: Clinical questions on rehabilitation (Cameron Swift)	The GDG discussed the questions proposed by CS on multidisciplinary rehabilitation. The GDG agreed the following assumptions: (1) Multidisciplinary rehabilitation (MDR) will be taken to incorporate the following core components of assessment and management (assuming the required degree of relevant specialist expertise in each case): medicine; nursing; physiotherapy; occupational therapy; social care. Additional components may include: nutrition, pharmacy, clinical psychology. (2) Types of hospital-based MDR (based on classification featured in Cameron 2009): Geriatric Orthopaedic Rehabilitation Unit (GORU), Geriatric Hip Fracture Programme (GHFP), Mixed Assessment and Rehabilitation Unit (MARU), (or their near equivalents), usual

Agenda Item	Discussion/Outcome
	care. (3) Types of community-based MDR: Intermediate Care Unit-based (IC), home-based (Early Supported Discharge) (ESD), Social Care Unit-based (SC) (or their near equivalents), usual care. (4) Usual care will be taken to mean "traditional" ad hoc or selective referral to some or all of the separate MDR components listed above without formal co-ordinated arrangements for multidisciplinary teamwork. (5) The clinical questions that emerged from this topic were: 1. Comparison of hospital-based MDR programmes with each other and usual care. 2. Comparison of late v early hospital-based MDR 3. Comparison of community-based MDR programmes with each other and usual care. 4. Comparison of late versus early versus sequential MDR 5. Comparison of the effectiveness of early (<3 days) v late (>3 days) mobilisation 6. Comparison of MDR where carer involvement explicit v all other. (6) The GDG agreed that the following outcomes were important: 1. Length of stay in secondary care. 2. Length of time before community resettlement/discharge. 3. Place of residence (compared with baseline) 12 months after fracture. 4. Short-, medium- and long-term functional status. 5. Short-, medium- and long-term quality of life. 6. Mortality at 1 year
8. Reporting economic evidence and modelling (Elisabetta Fenu) - workshop and discussion	This item had to be postponed as there wasn't sufficient time to cover it in this meeting.
10. Any other business, close and date of next meeting –	There was no other business to discuss. CGS closed the meeting and thanked everyone for attending **Date of next meeting is 29th October, at the NCGC office (Euston Road)**