National Clinical Guideline Centre for Acute and Chronic Conditions

HIP FRACTURE GUIDELINE

8th Guideline Development Group Meeting

Monday 26th April 2010, 10.30 – 16.00
Location: Sloane Room, Royal College of Physicians
11 St. Andrews Place, Regent's Park, London NW1 4LE

Minutes of the meeting

Present:

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

NCGC Saoussen Ftouh (SF), Elisabetta Fenu (EF), Carlos Sharpin (CS), Sarah Riley (SR), Jenny Hill (JH), Kate Lovibond (KL) and Antonia Morga (AM)

Apologies: Mr. Martin Wiese (MW), Dr Sally Hope (SH) and Dr Stuart White

Agenda Item	Discussion/Outcome
1. Introductions and apologies for absence, minutes of the last meeting and declaration of interests	CGS welcomed everyone to the 8th Hip Fracture GDG meeting. He introduced KL who is a Senior Health Economist at the NCGC. Apologies: CGS noted apologies from MW and SH. 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 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. Cost analysis of general versus regional anaesthesia in hip fracture patients (Stuart White, Expert Advisor)	CGS informed the GDG that Dr Stuart White had been appointed as an Expert Advisor on analgesia and anaesthesia. He was due to present his paper on a cost analysis of regional versus general anaesthesia in hip fracture patients but was unable to attend. AM presented this paper on his behalf.

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	The evidence provided in the paper was not thought to be sufficiently robust because of possible selection bias and the strong assumptions made which were not supported by evidence. Therefore, the GDG felt that it was not strong enough to show that there are significant differences in costs and in time between regional and general anaesthesia but it was the best available evidence. BH pointed out that it is also necessary to take staff costs into account as regional anaesthesia generally requires one extra person to help position the patient. **Action** • **AM to amend the economic considerations for recommendations as these were based on the White et al paper**
3. Health economics considerations for analgesia in hip fracture patients (Antonia Morga)	AM informed the GDG that the differences in prices of the various analgesics used for hip fracture patients did not appear to be significant. She asked whether the GDG thought there were any other costs that needed to be considered such as differences in administration costs. The GDG explained that non opioid drugs administration can be done by any nurse as part of the regular hospital rounds. However, opioid administration requires two trained nurses (at least band 5) and therefore administration times and trained nursing staff costs will need to be considered. SL pointed out that it is important to mention the difficulties of pain assessment for cognitively impaired patients in the write up possibly in the "other considerations" section **Action:** • **RG to discuss different types of nerve blocks that can be used for HF patients in the write up and to mention the difficulties with assessing pain in cognitively impaired patients.**
4. Feedback from the analgesia and anaesthesia workshop (Richard Griffiths)	RG presented the recommendations drafted during the analgesia and anaesthesia workshops. These were discussed and agreed with the GDG after minor additions and changes to the wording (see relevant write up chapter). The GDG noted that the guideline will need to cross refer to the VTE guideline with regards to warfarin reversal in hip fracture patients. **Actions:** • **RG/SF to make a note or recommendation about the fact that**

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	the choice of anaesthesia should not delay surgery and that patient preference should also be taken into account. • **RG to expand on introduction and to explain why the evidence is not so strong.** • **Need to say "be particularly aware of cognitively impaired in the introduction"** • **SL to send papers on pain score tests specific to cognitively impaired patients.** • **OS to provide an appendix or glossary on classification of opioids.**
5. Mobilisation strategies (Sarah Riley)	SR presented the evidence on early versus late and intensive versus non intensive mobilisation. <u>Early versus late mobilisation</u> The GDG suggested that it may be necessary to check economic implications of recommending early mobilisation within 48 hours as this would mean that nurses may need to work over the weekend and therefore may need to be paid overtime. This may well be the only important cost difference **Action:** • **Check nursing costs for weekend cover** <u>Intensive versus non intensive mobilisation</u> **Actions:** • **SL to draft preamble to mobilisation chapter within 2 weeks.** • **SL to define intensity to distinguish it from frequency**
6. Surgeon seniority (Carlos Sharpin)	CS presented a summary of the evidence on surgeon experience/seniority **Actions:** • **TC to check who did anterior and who did posterior approach as this can potentially be a confounding factor in the study** • **TC to define unsupervised as supervision varies between countries** • **SF to send a reminder to TC and BH to do their tasks**
7. Health Economics model on	AM presented an outline of the economic model for early versus late

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early versus late surgery (Antonia Morga)	surgery. The GDG discussed the complexities of developing the model such as distinguishing between medical and administrative reasons for delay and costing for 'normal' and 'out of hours' working as well as costs of extra theatres. OS suggested that the health economist who worked on the PBR may be able to help and suggested to put AM in contact with her. TC suggested that AM should also look at data from a district general hospital as well as a high volume hospital **Action:** • **KH will put Antonia in touch with a DGH manager who may be able to help** • **OS to send AM contact details for the health economist who worked on the PBR**
8. Health Economics model on hospital based MDR (Antonia Morga)	AM presented the outline of the MDR health economics model and discussed it with the GDG. KH thought that the 3.6% estimate of grade 2 pressure sores was too low. Probably more around 10%. CGS suggested that the model should be based on disability such as fairer access to social care. He also reminded the GDG that they will be consulting an expert advisor from SCIE. AJ and SL suggested a paper by Dolan and Torgerson (1998) where the authors estimated the social and health care use (outpatients' use of secondary health care, and GP visits) after a hip fracture. **Actions:** • **SF to chase up on recruiting a social care advisor from SCIE** • **AM to consider the Dolan and Torgerson 1998 study.**
9. Imaging for diagnosis of occult hip fractures (Chair and Professor Judy Adams)	CGS informed the GDG that Professor Judith Adams had been appointed as an Expert Advisor in radiology but was unable to attend this meeting. The GDG discussed the approach to be used in reviewing the clinical question on alternative radiological imaging for occult hip fractures. The following points were agreed: • Only look for diagnostic studies • MRI would be considered as the reference standard • Should not review criteria for strong clinical suspicion
10. Any other business, close	CGS closed the meeting and thanked everyone for attending

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and date of next meeting –	**Date of next meeting is Friday 11th June at the NCGC office; 180 Great Portland Street.**