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Hip Fracture
Guideline Consultation Comments Table
10 Nov 2010 – 12 January 2011

Type	Stakeholder	Order No	Document	Page No	Line No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	University Hospitals Birmingham NHS Foundation Trust	1.00	Full	37	4	The choice of extramedullary or Intramedullary implants for A2 fractures should be left to the discretion of the surgeon.	Thank you for your comment. After careful consideration we came to the conclusion that we do not agree. This recommendation was based on a clinical and economic systematic review of the evidence, taking into account the balance of benefits, harms and costs. As no significant clinical benefit was proven in this review for intramedullary devices, the GDG agreed to recommend the most cost effective device, extramedullary implants, for hip fracture patients.
SH	British Society of Skeletal Radiologists	4.00	Full	35	4	The use of CT for the detection of hip fractures should be further specified. The scan must be a thin section multislice CT with the use of multiplanar reformats.	Thank you for your comment. After careful consideration the GDG decided that in view of the lack of strong evidence the guidance did not warrant this level of detail.
SH	British Society of Skeletal Radiologists	4.01	Full	35	4	It should also be noted that in elderly osteoporotic patients the assessment of hip fractures may be limited by poor bone mineralisation. Therefore a negative CT may not exclude a fracture.	Thank you for your comment. This has already been stated in section 5.6 of the full version of the guideline.
SH	British Society of Skeletal Radiologists	4.02	Full	35	4	A positive CT does have a very high specificity and therefore CT remains a very useful test as it does have a high positive predictive value	Thank you for your comment. We agree and have in fact already stated this in several parts of the chapter

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SH	British Society of Skeletal Radiologists	4.03	Full	35	4	When CT is negative MRI should still be considered. If MRI cannot be performed an isotope bone scan should be considered.	Thank you for your comment. This is in agreement with what is stated in the document.
SH	Wirral University Teaching Hospital NHS Foundation Trust	5.00	NICE	7	22	Total hip replacements in trauma patients should only be performed or supervised by fully trained hip surgeons. I do not know of any hospital that can provide a daily hip surgeon supervised trauma list. We do not have that many hip surgeons in the UK. Upper limb and even the average trauma surgeon will have an unacceptable high complication risk. Patients for total hip replacements may have to wait until a specialist trauma list is available.	Thank you for your comment. Any orthopaedic surgeon should be able to perform total hip replacements independently by the end of their training. It should be part of the skill set for orthopaedic surgeons. Therefore, there should not be a need for a specialist hip surgeon.
SH	Wirral University Teaching Hospital NHS Foundation Trust	5.01	NICE	11	9	No trainee should ever be unsupervised. The wording is very open. Does supervision mean the consultant is scrubbed, in theatre, in the hospital, within 1 hour of the operating theatre, in the country or has discussed the case? Different trainees require a different level of supervision.	Thank you for your comments. We agree. We believe that trainees are often left unsupervised hence the recommendation. An amendment has been made to make a positive recommendation on supervision. In the narrative in the full guideline and the definition of the minimum requirements for supervision have been clarified The agreed change to the recommendation is **"Trainee and junior members of the anaesthetic, surgical and theatre team should be supervised by their consultants or senior staff in hip fracture procedures"**

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							The agreed definition for supervision is: "The list would be considered supervised when those responsible had adequate prior knowledge of the capabilities of the more junior members of the team and the specific problems they may encounter, and then used this knowledge to provide support and guidance."
SH	Wirral University Teaching Hospital NHS Foundation Trust	5.02	NICE	11	16	See total hip replacements above (number 1)	Any orthopaedic surgeon should be able to perform total hip replacements independently by the end of their training.It should be part of the skill set for orthopaedic surgeons. Therefore, there should not be a need for a specialist hip surgeon.
SH	Wirral University Teaching Hospital NHS Foundation Trust	5.03	NICE	12	2	Thompson hemiarthroplasty has been performed now for many years and has resulted in a satisfactory outcome in a large but not researched number of elderly patients. The use of modular total hip replacement stems may lead to trunnion related complications other monoblock hemiarthroplasty stems have a short follow up and are more expensive. If this recommendation is implemented I would suggest using the list price for a monoblock hemiarthroplasty other than the Thompson to calculate the NHS tariff.	Thank you for your comment. The calculation of NHS tariff does not form part of the scope nor of the remittance of our guideline.

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Type	Stakeholder	Order No	Document	Page No	Line No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Wirral University Teaching Hospital NHS Foundation Trust	5.04	Full	42	21	No trainee should ever be unsupervised. The wording is very open. Does supervision mean the consultant is scrubbed, in theatre, in the hospital, within 1 hour of the operating theatre, in the country or has discussed the case? Different trainees require a different level of supervision.	Thank you for comments. We agree. We also believe that trainees are often left unsupervised hence the recommendation. An amendment has been made to make a positive recommendation on supervision. In the narrative in the full guideline and the definition of the minimum requirements for supervision have been clarified The agreed change to the recommendation is **"Trainee and junior members of the anaesthetic, surgical and theatre team should be supervised by their consultants or senior staff in hip fracture procedures"** The agreed definition for supervision is: "The list would be considered supervised when those responsible had adequate prior knowledge of the capabilities of the more junior members of the team and the specific problems they may encounter, and then used this knowledge to provide support and guidance."
SH	Wirral University Teaching Hospital NHS Foundation Trust	5.05	Full	42	27	Total hip replacements in trauma patients should only be performed or supervised by fully trained hip surgeons. I do not know of any hospital that can provide a daily hip surgeon supervised trauma list. We do not have that many hip surgeons in the UK. Upper limb and even the average trauma surgeon will have an unacceptable high complication risk. Patients for total hip replacements may have to wait until a specialist trauma list is available.	Total hip replacements should be able to be performed by any orthopaedic surgeon independently by the end of their training. It should be part of the skill set for orthopaedic surgeons. Therefore, there should not be a need for a specialist hip surgeon.

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SH	Wirral University Teaching Hospital NHS Foundation Trust	5.06	Full	42	31	Thompson hemiarthroplasty has been performed now for many years and has resulted in a satisfactory outcome in a large but not researched number of elderly patients. The use of modular total hip replacement stems may lead to trunnion related complications other monoblock hemiarthroplasty stems have a short follow up and are more expensive. If this recommendation is implemented I would suggest to use the list price for a monoblock hemiarthroplasty other than the Thompson to calculate the NHS tariff.	Thank you for your comment. The calculation of NHS tariff does not form part of the scope nor of the remittance of our guideline.
SH	Stockport NHS foundation Trust	6.00	Full	7	30	Elderly care input and mental health status assessment	Thank you for your comment. This is a core component of orthogeriatric assessment, but we have now also made the linkage to mental health services more explicit by adding the following bullet point in recommendation 1.8.1: • liaison or integration with related services, particularly mental health, falls prevention, bone health, primary care and social services
SH	Stockport NHS foundation Trust	6.01	Full	8	27	Surgery in the first 24 hours – United they stand 1995	Thank you for your comment. The GDG are aware of this document. The rationale for selecting our threshold for timing of surgery is explained in the linking evidence to recommendations section 6.1.2 on page 65.

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SH	Stockport NHS foundation Trust	6.02	Full	34	15	What is regular physiotherapy a minimum should be stated	Thank you for your comment. After careful consideration, we came to the conclusion that we do not agree that this should be changed. There is insufficient evidence to suggest what the exact dosing of physiotherapy should be, and this will vary according to the physical capabilities of each patient - those who are very ill will not tolerate as much physical activity as those who are progressing well. Each person should be seen each day by a physiotherapist or the designate for mobilisation, and that this should be initiated as soon after surgery as possible, as stated in recommendations 1.7.1 and 1.7.2. We have indicated that the dosing should be based on a physiotherapist assessment. Hence the issue is one of professional judgement as we have no evidence to guide us any further. However, an additional observation is that the principles of management should not be any different for people with dementia, than those without. In addition, the physiotherapy review should be part of the continued co-ordinated orthogeriatric and multidisciplinary review as stated in the recommendation 1.8.1 regarding a Hip Fracture Programme. The linking evidence to recommendation has been updated to emphasize this.

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SH	Stockport NHS foundation Trust	6.03	Full	37	9	Same as above	Thank you for your comment. After careful consideration, we came to the conclusion that we do not agree that this should be changed. There is insufficient evidence to suggest what the exact dosing of physiotherapy should be, and this will vary according to the physical capabilities of each patient - those who are very ill will not tolerate as much physical activity as those who are progressing well. Each person should be seen each day by a physiotherapist or the designate for mobilisation, and that this should be initiated as soon after surgery as possible, as stated in recommendations 1.7.1 and 1.7.2. We have indicated that the dosing should be based on a physiotherapist assessment. Hence the issue is one of professional judgement as we have no evidence to guide us any further. However, an additional observation is that the principles of management should not be any different for people with dementia, than those without. In addition, the physiotherapy review should be part of the continued co-ordinated orthogeriatric and multidisciplinary review as stated in the recommendation 1.8.1 regarding a Hip Fracture Programme. The linking evidence to recommendation has been updated to emphasize this.

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SH	Stockport NHS foundation Trust	6.04	Full	38	16	Crucial but how can this be policed – how feasible is it?	Thank you for your comment. We agree and have clarified the governance responsibilities of the Hip Fracture Programme Team by adding a bullet point to the Hip Fracture Programme recommendation: 'clinical and service governance responsibility for all stages of the pathway of care and rehabilitation, including those delivered in the community.' In addition, the GDG consider that care home managers can feed back to individual Trusts/community rehabilitation teams where they feel their patients have been denied further rehabilitation
SH	Stockport NHS foundation Trust	6.05	Full	134	5	Nurses could do this with training in out of hours	Thank you for your comments. We have now added the following paragraph to the "Other considerations" in section 11.2.2: "The GDG also noted that albeit the intervention should be overseen by physiotherapists it is also important for nurses to re-enforce and encourage patients' mobility at all other times, under the guidance of the physiotherapist."
SH	LifeBlood: The Thrombosis Charity	9.00				The only comment we would wish to make is that there is no specific reference to risk assessment for thromboprophylaxis in the guidelines. We are aware that NICE Guideline 92 already covers TTP in hip surgery; however, we though it worthy of mention as VTE is a significant cause of mortality and morbidity in hip surgery.	Thank you. We have now given greater emphasis to this by adding a statement which refers to existing NICE guidance before the recommendations in the NICE and full versions of the guideline.

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SH	British Nuclear Medicine Society	11.00	Full	2		No radiologist or nuclear medicine specialist on the guideline development group. This diminishes advice and restricts knowledge base available to committee	Thank you for your comment. The GDG enjoys the benefit of comprehensive regular advice from Professor Judith Adams (Consultant and Honorary Professor of Diagnostic Radiology) who is a formally appointed external expert advisor
SH	British Nuclear Medicine Society	11.01	Full	12	21	No radiologist or nuclear medicine specialist on guideline group despite key recommendations on imaging being made	Thank you for your comment. The GDG enjoys the benefit of comprehensive regular advice from Professor Judith Adams (Consultant and Honorary Professor of Diagnostic Radiology) who is a formally appointed external expert advisor
SH	British Nuclear Medicine Society	11.02	Full	35	4	No mention is made of the value of bone scanning as an alternative to MRI, despite an established evidence base compared to CT. It is important to understand that the use of the bone scan in occult hip fracture has a long established use in clinical practice and is still used for this purpose in many centres. The sensitivity of the bone scan is superior to x-rays and has very typical appearances and would be expected to be positive in virtually every case by 72 hours post fracture. The bone scan is recognised widely to have a high sensitivity for the detection of occult fracture. With regard to hip fracture 2 seminal papers are well known in the Nuclear Medicine specialty. The study of	Thank you for your comment. (1) This statement is not strictly correct. On page 51 it is stated that if MRI is unavailable, RNS or CT should be performed. (2) The studies you mention did come up in our search but were not included either because they were not direct comparisons of MRI to RNS/CT or because the GDG considered them to be dated (going back to 1987). Since their publication there have been substantial technical developments in both CT and MRI (improved image quality, more rapid scanning) so that some of the findings of earlier studies are likely now to have reduced applicability.

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						Matin P (1), in a series of 204 pts showed that 95 % of fractures were detected within 72 hours of injury and a specific study of hip fractures by Holder et al (2) that examined the use of bone scans mostly less than 72 hours after injury in occult fracture in 179 pts showed there was very high sensitivity of 0.978. The greater sensitivity of bone scan over x-ray was also shown in a study of Fairclough et al 1987 (3) where in 43 pts with suspected fractures but normal x-rays, the bone scan correctly diagnosed and excluded fractures in all patients. 1. Matin P., The appearance of bone scans following fractures, including immediate and long-term studies. J Nucl Med. 1979. vol 20/12 (1227-1231) 2. Holder L.E., Schwartz C., Wernicke nP.G., Michael R.H., Radionuclide bone imaging in the early detection of fractures of the proximal femur 9hip)L multifactorial analysis. Radiology; 1990; Vol174/2 (509-515). 3. Fairclough J., Colhoun E., Johnston D., Williams L.A., Bone scanning for suspected hip fractures. A prospective study in elderly patients. J Bone and Joint Surg Brit. 1987 vol 69/2; 251-253.. The bone scan is very comparable to	

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						MRI for detection of occult hip fracture and this has been noted in several studies. A small comparative study of bone scans and MRI in 23 patients with suspected hip fractures and normal x-rays in 1989 showed similar results (4). A larger later comparative study of bone scan and MRI in occult hip fracture in 62 patients showed 36 patients had positive MRI and bone scans and 23 negative MRI and bone scans. 1 pt was positive on MRI but negative on bone scan at 24 hours post injury. This study was then later positive (5). A small study in 1995 comparing CT and MRI showed inferior results for CT scanning (6) 4. Deutsch A.L., Mink J.H., Waxman A.D., Radiology 1989. Vol 170/1 113-116. 5. Rizzo P.F., Gould E.S., Lyden J.P., Asnis S.E., Diagnosis of occult fractures about the hip. Magnetic resonance imaging compared with bone scanning. J Bone and Joint Surgery – Am. 1993; 75/3 395-401. 6. Lubovsky O., Liebergall M., Mattan Y., Weil Y., Mosheiff R., Early diagnosis of occult hip fractures, MRI versus CT scan. Injury. 2005: 36/6: 788-792.	

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SH	British Nuclear Medicine Society	11.03	Full	39	13-23	No mention made of the technological developments in Nuclear medicine especially SPECT/CT which is increasingly available and could be next choice after MRI, provided available in 24 hours.	Thank you for your comment. SPECT/CT was included both in our protocol and in the search strategies. However, we did not retrieve any relevant studies that could be included in our review and based on which we could make recommendations. The GDG did recognise the important advances being made in this field and have therefore made a recommendation for further research.
SH	British Nuclear Medicine Society	11.04	Full	39	9-11	No mention of important research to compare early SPECT/CT bone scan or conventional bone scan to MRI and CT. It would be sensible to include all imaging modalities in this exercise. If bone scan is better than CT then efforts should be made to make it available within 24 hours.	Thank you for your comment. SPECT/CT was included in our protocol and search strategies. However, we did not retrieve any relevant studies that could be included in our review. After careful consideration, the GDG's view was that SPECT/CT would not be better than thin section CT. It also retains the problem of delay (3 days) to evidence of increased uptake of radionuclide in the fracture site, as outlined in the document.
SH	British Nuclear Medicine Society	11.05	Full	47	5-13	False positive results are raised as an issue with bone scan. This is very rare and no more than other imaging modalities, CT and MRI which also give false positives with other pathology and false negatives. The fracture appearances on bone scan are very characteristic.	Thank you for your comment. Whilst the GDG recognised that false results can be obtained with all the modalities, there are still further limitations with RNS which are stated in the in the guideline. These include delay in obtaining positive images, limited out of hours access and longer procedure times than CT or MRI.

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SH	British Nuclear Medicine Society	11.06	Full	47	19	Only 2 studies of bone scan considered. Although the literature in this field has always been limited, other studies should be considered. See above	Thank you for your comment. The GDG recognise that there are many studies on bone scan. The aim of our research was not to review the literature specific to bone scans but we followed a precise protocol which aimed to identify the best alternative to MRI in diagnosing occult hip fracture. The GDG started with a baseline agreed designation of MRI as gold standard for the diagnosis of occult hip fractures rather than an open comparison of the range of different modalities with one another. This is why only two studies (in accordance with the protocol) were included in the review.
SH	British Nuclear Medicine Society	11.07	Full	52	5-7	The advice of using CT as an alternative to MRI is based on the guideline group consensus without a complete review of the literature and without an imaging expert on the group.	Thank you for your comment. The guidance on CT was arrived at through consensus after a systematic review of the literature and careful consideration by the GDG in consultation with Professor Judith Adams (Consultant and Honorary Professor of Diagnostic Radiology) who was a formally appointed expert advisor. She provided comprehensive regular advice and attended Guideline Group meetings as necessary.
SH	College of Occupational Therapists	12.00		General		The College is pleased that the guideline provides a balanced focus between both surgical and multi-disciplinary aspects of care.	Thank you for your comment.

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SH	College of Occupational Therapists	12.01	NICE version	13	Section 1.8.4	The concept of utilising an 'Early Supported Discharge' team to facilitate earlier discharge whilst ensuring the patient receives ongoing MDT care is a good one, and will hopefully be taken up by more trauma and orthopaedic centres within the NHS.	Thank you for your comment
SH	College of Occupational Therapists	12.02	NICE version	13	Section 1.8.5	The need to better manage transfer of patients to community hospitals is a very valid point as this is often seen as a means of freeing up beds in acute hospitals, and without a structured plan patients may then remain in community beds for some time. By ensuring that the Hip Fracture Programme takes clinical and managerial responsibility for this transfer, setting targets for further rehabilitation and agreeing length of stay, patient care should continue to be focused on discharge back in to the community in a timely manner.	Thank you for your comment
SH	College of Occupational Therapists	12.03	NICE version	14	Section 1.8.6	This section highlights that patients admitted with hip fracture from care or nursing homes should have access to the same multi-disciplinary rehabilitation programme as other patients, ie. within hospital, in the community or as part of an early supported discharge programme. This is a positive statement, as this patient group may not currently be receiving the same level of treatment, with the tendency to discharge back to the facility once a level of function / mobility has been reached that the facility is able to provide	Thank you for your comment

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						care for, with no follow-up. By providing community follow-up, the patient is given more opportunity to regain their previous level of function / mobility.	
SH	College of Occupational Therapists	12.04		General		The College is pleased to see occupational therapy specifically mentioned in research recommendation 4.4, as well as scope for involvement in 4.3 and 4.5. There will certainly be an opportunity for occupational therapists in trauma and orthopaedics to be involved in this in the coming years.	Thank you for your comment
SH	Amgen UK Ltd	13.00	Full	13	25	Our comments concern the Related NICE Health Technology Appraisals cited in the document, which should also include the recently concluded TA204 Denosumab for the prevention of osteoporotic fractures in postmenopausal women as the most recent appraisal. This is also not included in the short document. In addition, whilst osteoporosis is not within the scope of this guideline, a clearer and more robust statement linking this hip fracture guidance to the secondary prevention technology appraisals for osteoporosis drugs is required i.e. NICE TA161 and TA204, as well as ensuring that the linkage to NICE CG21 on falls is expressly made, for example by highlighting these in bold in a text box.	Thank you. Please also see the responses to your comments 13.01 -13.06. We have now given greater emphasis to this by adding a statement which refers to existing NICE guidance before the recommendations in the NICE and full versions of the guideline. This incorporates reference to TA204 and the other guidance to which you refer in these comments.

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SH	Amgen UK Ltd	13.01	Full	15	17	Our comments concern the NICE osteoporosis clinical guideline, which has been suspended and will be replaced by a short clinical guideline on fracture risk assessment.	Thank you. Please see our response to your comment under 13.00 above.
SH	Amgen UK Ltd	13.02	Full	143	14	Our comments are that the references need to include the recently concluded NICE TA204	Thank you. Please see our response to your comment under 13.00 above.
SH	Amgen UK Ltd	13.03	Full	159		Our comment is that under 'Other considerations' the references should include the recently concluded NICE TA204.	Thank you. Please see our response to your comment under 13.00 above.
SH	Amgen UK Ltd	13.04	Appendices	208	20	Our comments concern the Related NICE Health Technology Appraisals cited in the document, which should also include the recently concluded TA204 as the most recent appraisal.	Thank you. Please see our response to your comment under 13.00 above.

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SH	Amgen UK Ltd	13.05	Appendices	209	14	Our comments concern the NICE osteoporosis clinical guideline, which has been suspended and will be replaced by a short clinical guideline on fracture risk assessment.	Thank you. Please see our response to your comment under 13.00 above.
SH	Amgen UK Ltd	13.06	Appendices	636	37	Our comments are that the references need to include the recently concluded NICE TA204	Thank you. Please see our response to your comment under 13.00 above.
SH	British Pain Society	14.00	Full &Nice	General		We welcome the publications of these guidelines. We support the emphasis that is included in the guideline on the adequate management of pain. Our comments are restricted to this aspect of the guidelines	Thank you for your comment.
SH	British Pain Society	14.01	Full	69	3	We welcome and fully support the statement that 'Pain is a major component of the patient experience following a hip fracture.'	Thank you for your comment. The GDG considered that this was a key priority.

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SH	British Pain Society	14.02	Full	69	16	We welcome the statement regarding the difficulties of assessing pain in older adults with cognitive impairment. We would recommend that those needing guidance consult the BPS, RCP and BGS guidance 'The assessment of pain in older people: National Guidelines (2007)' available at: http://www.britishpainsociety.org/pub_professional.htm#assessmentpop. Where verbal report is not possible, pain should be assessed using an appropriate behavioural assessment tool	Thank you for your comment. We have added the following statement in 'other considerations' which refers to the guideline: "Additional broad guidance on the assessment of pain in general in older people is given in a joint British Pain Society/British Geriatrics Society document to be found at: http://www.bgs.org.uk/Publications/Publication%20Downloads/Sep2007PainAssessment.pdf"
SH	British Pain Society	14.03	Full	76	1	It is not clear what 'There are no identifiable harms from carrying out this assessment' is referring to	Thank you for your comment. This statement refers to the clinical assessment of pain when examining the fractured leg which involves gentle rotation of the leg. This may be associated with some degree of pain but would not otherwise cause any additional harm to the patient. The GDG therefore did not identify any significant harms associated with this assessment. We have clarified this in the linking evidence to recommendations section with the following text:
SH	British Pain Society	14.04	Full	77	17	Misspelling of opioids	Thank you for your comment. We have corrected this.

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SH	British Pain Society	14.05	Full	77	11	While the statement, 'Repeated use of opioids may cause dependence and tolerance but this should not be a deterrent in the control of pain in patients who may have a terminal illness' the relevance of this statement to the treatment of Hip fracture is unclear. The assessment of previous opioid use is however important to identify any pre-existing tolerance due to opioid treatment of existing pain.	Thank you for your comment. We have amended the statement to give greater clarity. It now reads as follow: Repeated use of opioids may cause dependence and tolerance. While this should be borne in mind, it should not deter the achievement of effective pain relief in the acute situation of hip fracture. In those for whom the fracture is an incident within the pathway of a terminal illness, the palliative context of that illness should also be an important consideration. In particular, if there is a history of previous opioid use, the existence of acquired tolerance may necessitate the use of higher doses to relieve hip fracture pain.
SH	British Pain Society	14.06	Full	81	3	We welcome the recommendation for further research, however in light of the limited evidence based identified in the guidelines we would recommend that additional questions are also identified including exploration of the most appropriate approaches to pain assessment in older people with cognitive impairement	Thank you for your comment. The GDG considered a number of potential recommendations for research and voted on the ones that they considered should be prioritised. These were the ones that were included in the guideline.
SH	The College of Optometrists and the Optical Confederation	15.00	NICE and Full	Gener al		The introduction of the consultation document outlines that aspects that are covered by parallel guidance are not included in the draft hip fracture guidelines (page 8 of consultation document). Although there is a specific NICE Clinical Guideline on Falls (CG 21), there is unfortunately nothing in this document that relates to vision or the importance of regular sight testing. We are aware that a decision	Thank you for your detailed comment and review. We have now added an additional statement at the beginning of the recommendations that strengthens the linkage to existing NICE guidance, including CG21. Vision testing is, however, outside the scope of the hip fracture guideline, but we would anticipate this may be further considered when CG21 is reviewed.

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						will be made this year about whether to review CG21 before November 2011. As vision has not been covered to date by parallel guidance, we would like to take this opportunity to make the case for the role of regular sight testing in falls prevention. There are, of course, a number of contributing factors that can substantially increase the risk of a fall (and hence a hip fracture), which would include problems with vision, among other things. We would strongly recommend that measures are included in the most relevant NICE guidelines (which may not be this one as it is focused on management of hip fracture post admission) that specifically alerts medical practitioners and older people, their families and carers and the public to these contributory factors. We would particularly emphasise the benefits of regular sight testing for at risk groups. We have also found that many medical practitioners are also frequently unaware of the availability of domiciliary sight testing for housebound patients. We would also recommend that guidelines on falls prevention should also flag up the option of a domiciliary sight test for housebound patients (which overlap substantially with the at risk groups). Many papers have shown that visual impairment is a significant risk factor for hip	

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						fracture (Cummings et al 1995 (1), Grisso et al 1991 (2), DargentMolina et al 1996 (3)). In addition, Cox et al 2005 (4) found that there was significantly poor optometric and ophthalmic contact in patients who sustained hip fracture. Many of these patients had visual impairment and importantly, the great majority (66%) had visual impairment that was correctable as it was caused by uncorrected refractive error or untreated cataract. We would be willing to work with NICE to assist them with including the importance of assessing a person's vision and the availability of NHS eye care services in the guidance. **References and abstracts** (1) **Risk factors for hip fracture in white women** Cummings SR, Nevitt MC, Browner WS, Stone K, Fox KM, Ensrud KE, Cauley JC, Black D and Vogt TM NEJM 1995 332(12) 767-773 **Background**. Many risk factors for hip fractures have been suggested but have not been evaluated in a comprehensive prospective study. **Methods.** We assessed potential risk factors, including bone mass, in 9516 white women	

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						65 years of age or older who had had no previous hip fracture. We then followed these women at 4-month intervals for an average of 4.1 years to determine the frequency of hip fracture. All reports of hip fractures were validated by review of x-ray films. **Results.** During the follow-up period, 192 women had first hip fractures not due to motor vehicle accidents. In multivariable age-adjusted analyses, a maternal history of hip fracture doubled the risk of hip fracture (relative risk, 2.0; 95 percent confidence interval, 1.4 to 2.9), and the increase in risk remained significant after adjustment for bone density. Women who had gained weight since the age of 25 had a lower risk. The risk was higher among women who had previous fractures of any type after the age of 50, were tall at the age of 25, rated their own health as fair or poor, had previous hyperthyroidism, had been treated with long-acting benzodiazepines or anticonvulsant drugs, ingested greater amounts of caffeine, or spent four hours a day or less on their feet. Examination findings associated with an increased risk included the inability to rise from a chair without using one's arms, poor depth perception, poor contrast sensitivity, and tachycardia at rest. Low calcaneal bone density was also an independent risk factor. The incidence of hip fracture ranged from 1.1 (95 percent confidence interval, 0.5 to 1.6) per 1000 woman-years among women with	

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						no more than two risk factors and normal calcaneal bone density for their age to 27 (95 percent confidence interval, 20 to 34) per 1000 woman-years among those with five or more risk factors and bone density in the lowest third for their age. **Conclusions.** Women with multiple risk factors and low bone density have an especially high risk of hip fracture. Maintaining body weight, walking for exercise, avoiding long-acting benzodiazepines, minimizing caffeine intake, and treating impaired visual function are among the steps that may decrease the risk. (2) **Risk factors for falls as a cause of hip fracture in women.** Grisso JA, Kelsey JL, Strom BL, Chiu GY, Maislin G, OBrien LA, Hoffman S, Kaplan F NEJM 1991 19 1326-1331 **Background**. Although even in the elderly most falls are not associated with fractures, over 90 percent of hip fractures are the result of a fall. Few studies have assessed whether the risk factors for falls are also important risk factors for hip fracture. **Methods.** To examine the importance of risk factors for falls in the epidemiology of hip fracture, we performed a case-control study of 174 women (median age, 80 years) admitted with a first hip fracture to 1 of 30	

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						hospitals in New York and Philadelphia. Controls, matched to the case patients according to age and hospital, were selected from General surgical and orthopedic surgical hospital services. Information was obtained by direct interview. **Results**. As measured by the odds ratio, increased risks for hip fracture were associated with lower-limb dysfunction (odds ratio = 1.7; 95 percent confidence interval, 1.1 to 2.8), visual impairment (odds ratio = 5.1; 95 percent confidence interval, 1.9 to 13.9), previous stroke (odds ratio = 2.0; 95 percent confidence interval, 1.0 to 4.0), Parkinson's disease (odds ratio = 9.4; 95 percent confidence interval, 1.2 to 76.1), and use of long-acting barbiturates (odds ratio = 5.2; 95 percent confidence interval, 0.6 to 45.0). Of the controls, 44 (25 percent) had had a recent fall. The case patients were more likely than these controls to have fallen from a standing height or higher (odds ratio = 2.4; 95 percent confidence interval, 1.0 to 5.7). Of those with hip fracture the younger patients (< 75 years old) were more likely than the older ones (greater-than-or-equal-to 75 years old) to have fallen on a hard surface (odds ratio = 1.9; 95 percent confidence interval, 1.04 to 3.7). **Conclusions.** A number of factors that have been identified as risk factors for falls are also associated with hip fracture, including	

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						lower-limb dysfunction, neurologic conditions, barbiturate use, and visual impairment. Given the prevalence of these problems among the elderly, who are at highest risk, programs to prevent hip fracture should include measures to prevent falls in addition to measures to slow bone loss. (3) **Fall-related factors and risk of hip fracture: The EPIDOS prospective study** DargentMolina P, Favier F, Grandjean H, Baudoin C, Schott AM, Hausherr E, Meunier PJ, Breart G Lancet 1996 348(9021) 145-149 **Abstract:** Background Most hip fractures result from falls. However, the role of fall-related factors has seldom been examined. Comparison of the predictive value of these factors with that of bone mineral density (BMD) has important implications for the prevention of hip fractures. **Methods** We assessed femoral-neck BMD by dual-photon X-ray absorptiometry and potential fall-related risk factors, which included self-reported physical capacity, neuromuscular function, mobility, visual function, and use of medication in 7575 women, aged 75 years or older, with no history of hip fracture recruited at five centres in France. We followed up these women every 4 months to record incident hip fractures. During an average of 1.9 years of	

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						follow-up, 154 women suffered a first hip fracture. **Findings:** In age-adjusted multivariate analyses, we found four independent fall-related predictors of hip fracture: slower gait speed (relative risk=1.4 for 1 SD decrease [95% CI 1.1-1.6]); difficulty in doing a tandem (heel-to-toe) walk (1.2 for 1 point on the difficulty score [1.0-1.5]); reduced visual acuity (20 for acuity less than or equal to 2/10 [1.1-3.7]); and small calf circumference (1.5 [1.0-2.2]). After adjustment for femoral-neck BMD, neuromuscular impairment-gait speed, tandem walk-and poor vision remained significantly associated with an increased risk of subsequent hip fracture. With high risk defined as the top quartile of risk, the rate of hip fracture among women classified as high risk based on both a high fall-risk status and low BMD was 29 per 1000 woman-years, compared with 11 per 1000 for women classified as high risk by either a high fall-risk status or low BMD; for women classified as low risk based on both criteria the rate was five per 1000. **Interpretation** We conclude that neuromuscular and visual impairments, as well as femoral-neck BMD, are significant and independent predictors of the risk of hip fracture in elderly mobile women, and that their combined assessment improves the prediction of hip fractures.	

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						(4) **Optometric and ophthalmic contact in elderly hip fracture patients with visual impairment.** Cox A, Blaikie A, Macewen CJ, Jones D, Thompson K, Holding D, Sharma T, Miller S, Dobson S, Sanders R. Ophthalmic Physiol Opt. 2005 Jul;25(4):357-62. **Aim:** To describe previous contact with optometry and ophthalmic services in a group of elderly patients with and without visual impairment (VI) who had fallen and sustained a fractured neck of femur. **Method:** A cross sectional study of 537 patients aged 65 and over who had undergone hip fracture surgery in four Scottish centres (Glasgow, Ayr, Dundee and Fife). All patients had an in-depth optometric history, ophthalmic history and examination. **Results:** Three hundred and ninety-three (79%) patients reported optometric contact in the 3 years preceding surgery and 107 (21%) patients had not seen an optometrist for more than 3 years. In the latter group, 64 had VI, which was due to uncorrected refractive error in 17 (27%) and untreated cataract in 20 (31%). VI (best binocular visual acuity of 6/18 or less) was found in 239 (46%) patients. A past ophthalmic history was present in 257 (50%) patients. Only 39 (16%) patients with	

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						VI were under ophthalmic care at the time of the study. **Conclusions:** There was significantly poor optometric and ophthalmic contact in patients who had VI and had fallen and sustained hip fracture. A proportion of the VI (66%) was due to uncorrected refractive error and untreated cataract. Public health providers should be made aware of the fact that current optometric and ophthalmic care pathways are not accessed by this group of elderly patients with VI and at risk of falling.	
SH	Society and College of Radiographers	16.00	Full	35	5	Consider impact on MRI and CT services increased demand in relation to numbers and urgency; will this be out-of-hours? However, if a local protocol can be agreed whereby the person who reports the radiograph and the person doing the clinical examination concur how to proceed with regard to equivocal x-ray examinations then the impact can be limited.	Thank you for your comment. What is being suggested in the guideline is what is already occurring in clinical practice. With occult hip fractures only accounting for 3-9% (rare) of hip fractures the impact on service provision will be small and as stated by COR local practical protocols can be agreed around local facilities and expertise. In addition, NICE will be publishing implementation tools shortly after the publication of this Guideline which we hope will help with this matter

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SH	Society and College of Radiographers	16.01	Full	35	10	Consider impact of increased throughput of this surgery requiring Radiographic input in the Operating Theatre e.g. Dynamic Hip Screw fixation. However, despite more timely operative procedures for all hip fracture patients, there may also be a reduction in radiographer time in theatre due to total hip replacements replacing the current practice of cannulated screws for intra-capsular fractures. Replacing IM nails with DHS's should not alter the workload since DHS's take less time than IM nails.	Thank you for your comment. Carrying out hip fracture surgery within a prescribed time will not increase workload. Having the procedures carried out on a planned trauma list rather than an ad hoc emergency list should allow easier workforce planning.
SH	Society and College of Radiographers	16.02	Full	135	1	Consider post-operative plain film imaging in relation to timing of mobilisation e.g. if Physiotherapists are waiting for post-op imaging before mobilisation and until the Orthopaedic surgeons agree that mobilisation could take place prior to imaging. Radiographers delayed post-operative imaging to allow patients to recover a little and to reduce patient discomfort during imaging. A small gap of 1-2 days makes this examination much less painful for the patient. However, if the low dose intra-operative images undertaken during a DHS are of a high quality and complete, then more post-opertative imaging should not be required unless a failure is suspected.	Thank you for your comment. This area falls outside the scope of the guideline. Therefore we could not provide a response.

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SH	Society and College of Radiographers	16.03			General	There does not seem to be any mention of post-discharge follow-up imaging on these patients	Thank you for your comment. post-discharge follow-up imaging falls outside the scope of the guideline and therefore we are unable to provide a more specific response.
SH	Society and College of Radiographers	16.04	Full	48	4	No consideration has been made to the alternate use of RNS using hybrid imaging (SPECT-CT) when MRI is unavailable or contraindicated. This may yield more useful information than RNS bone scans alone. And may be more sensitive in some cases than CT alone. However, it is noted that these are expensive, have a high dose and not Generally available out of hours.	Thank you for your comment. SPECT/CT was included in our protocol and search strategies. However, we did not retrieve any relevant studies that could be included in our review. Your points about cost, dose and availability were also considered. The GDG did however recognise its potential importance and have therefore made a recommendation for further research.
SH	Society and College of Radiographers	16.05	Full	331	31	Consider plain film chest Radiography on patients with co morbidity of suspected chest infection – although it is expected that most elderly patients will have a chest image taken prior to surgery anyway but will the urgency of this be increased. Pre-op chest x-rays in the over 65's with no recent (prior 4 weeks) chest x-ray and a hip fracture would be good practice and save time and improve patient management.	Thank you for your comment. The recommendation for detailed orthogeriatric medical assessment will ensure this possibility is given due consideration.

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SH	Society and College of Radiographers	16.06	Full	35	4	Lateral images done on patients with inter or per trochanteric fractures (except where there is doubt i.e. possible basi cervical fractures) are pointless as the management will be a DHS and they WILL be manipulated in theatre under fluoroscopic control and therefore the lateral adds nothing to the original examination. Laterals are still useful and necessary for intra capsular and sub-trochanteric fractures. I believe time spent achieving a good quality AP image that clearly demonstrates the extent of the fracture is of much more use to the orthopaedic surgeon than a poorly exposed foreshortened lateral image, the position of which is painful for the patient and cannot be relied upon once the patient has been transferred into a bed from the AE trolley	Thank for your comment. The guideline group are of the strong opinion that lateral radiographs in hip fracture patients are a requirement for adequate diagnosis and pre-operative planning. It is important to note that this recommendation is specific to the diagnosis of occult hip fractures. If fracture is obvious on AP projection then no further projections may be necessary.
SH	Stryker UK Ltd	17.00	Full	109	1	Design of implant enables surgeon to ensure a wide range of choice and fit along with a forgiving nature - to enable surgeons in training to operate without compromising on clinical outcome(ref Carrington et al, JBJS 2009, Exeter 15-17yr results, 50% of series performed by surgeons in training, in a THR which is more complex operation than #NOF which using stem only . Optimal head size should be considered to reduce the risk of dislocation.	Thank you we agree. As we did not identify RCT evidence comparing the optimum head size for to be used for total hip replacements we have made a research recommendation.

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SH	Stryker UK Ltd	17.01	Full	127	7	We do not dispute, as the authors point out, that the estimated risk ratio derived in this NICE guideline may have developed due to including studies with original or outdated designs of the nail that are no longer implanted. This is evident in the fact that more than half of the studies cited are over a decade old, and the NICE authors acknowledgment that the nail design has evolved in the past couple decades - these design changes have resulted in improved outcomes such as a reduction in the rate of shaft fractures. We do therefore dispute NICE's decision to include outcomes from studies of old nail designs in with outcomes of newer improved nail designs. Stryker has an ongoing meta-analysis underway. It is being conducted to a high standard of scientific methodology and neutrality. We are attaching under separate cover a preliminary report with the findings of this analysis for your information. This is confidential and not for wider distribution. As some additional analysis are still being performed, Stryker may come back with further arguments on the relative merits of sliding hip screw vs nailing.  CONFIDENTIAL - Junicon Report on Hip	Thank you for your comment. We agree that these studies could have been analysed differently e.g.by sub grouping the studies by year of publication. We have included an additional meta-analysis in the appendix including only studies published after 2000. It has been acknowledged in the linking evidence to recommendation section (10.6.1.5) that original nail designs that may no longer be implanted have been included in the analysis, but also that a high number of studies have been included that have very similar outcomes with negligible heterogeneity. We have added a link to the new meta-analysis to Appendix G and have stated that by sub grouping the data, including only studies from 2000, there are no changes to the evidence statements or recommendations. The linking evidence to recommendation has been updated to reflect this.

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SH	Stryker UK Ltd	17.02	Full	92	1	Please refer to Point 1 above	Thank you for your comment. The page and line number you refer to corresponds to the recommendation regarding trainees undertaking surgery or anaesthesia on hip fracture patients. We are unsure what your comment refers to and are unable to provide a response.
SH	NHS Direct	18.00	General			NHS Direct welcome the guideline and have no comments on its content.	Thank you for your comment.
SH	Chartered Society of Physiotherapy (CSP)	19.00	Full	General		Thank you for the opportunity to comment on this well constructed guideline.	Thank you for your comment.
SH	Chartered Society of Physiotherapy (CSP)	19.01	Full	34	31	What level of cognitive impairment should exclude someone from the opportunity of ESD? How would this be measured?	Thank you for your comment. We agree and have amended the recommendation so that the second bullet point reads: • has the mental ability to participate in continued rehabilitation The GDG based this wording on the paper from Crotty et al.,{CROTTY2003}, in which cognitively intact was defined as 'patients who have the mental capacity to participate in a

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							rehabilitation programme'. In addition the GDG were reluctant to define cognitive impairment based on a score, recognising the fact the cognition fluctuates and that rehabilitation goals need to be set individually by the multidisciplinary team. Diagnosis of dementia is covered in the NICE dementia guidelines (www.nice.org.uk/guidance/CG42) and delirium in the NICE delirium guidelines (www.nice.org.uk/guidance/CG103).
SH	Chartered Society of Physiotherapy (CSP)	19.02	Full	36	24	This is paramount for effective rehabilitation and should be emphasised	Thank you for your comment. We agree this is important. This was not listed as one of the key areas for implementation as it was believed other recommendations should be prioritised.
SH	Chartered Society of Physiotherapy (CSP)	19.03	Full	38	5	Cognitive impairment is stated as a contraindication to ESD, however many care home residents have some form of cognitive impairment – so is this a contradiction? If a person is being discharged early, just because they live in a care home, it must be ensured that there is access to the same resources as a community dwelling person e.g. equipment (chair raisers, etc).	Thank you for your comment. We agree and have amended the recommendation so that the second bullet point reads: • has the mental ability to participate in continued rehabilitation The GDG based this wording on the paper from Crotty et al.,{CROTTY2003}, in which cognitively intact was defined as 'patients who have the mental capacity to participate in a rehabilitation programme'. In addition the GDG were reluctant to define cognitive impairment

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							based on a score, recognising the fact the cognition fluctuates and that rehabilitation goals need to be set individually by the multidisciplinary team. Diagnosis of dementia is covered in the NICE dementia guidelines (www.nice.org.uk/guidance/CG42) and delirium in the NICE delirium guidelines (www.nice.org.uk/guidance/CG103).
SH	Chartered Society of Physiotherapy (CSP)	19.04	Full	38	7	'Rehabilitation potential' is a very grey area and family, staff and patient may have differing views. Would a statement encouraging discussion and agreement on this help implementation?	Thank you for your comment. We agree and have amended the bullet point to read: 'has not yet achieved their full rehabilitation potential, as discussed with the patient, carer and family.'
SH	Chartered Society of Physiotherapy (CSP)	19.05	Full	38	16	This needs emphasis as patients are often denied rehabilitation if they are in a care home.	Thank you for your comment. We agree on the need for emphasis and think that this is adequately covered in the recommendation: 'Patients admitted from care or nursing homes should not be excluded from rehabilitation programmes in the community or hospital, or as part of an early supported discharge programme.'

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SH	Chartered Society of Physiotherapy (CSP)	19.06	Full	41	21	Important research point - in clinical practice often see patients complete rehab as soon as can safely walk, rather than having resources to try to push for full rehab to an optimum outcome. However patients who do get referred onto my DH setting do have huge improvements with targeted resistance training. There is a wealth of evidence to support strength, balance, flexibility, and gait training to reduce falls – it would be valuable to see whether this correlates with prevention of second hip fracture.	Thank you for your comment. This comment is outside the remit of the guideline. Falls prevention is covered by separate NICE Guidance: Falls. NICE clinical guideline 21 (2004). Available from www.nice.org.uk/guidance/CG21 However, we have added a more explicit statement at the beginning of the full list of recommendations which emphasises the need for management of hip fracture patients according to other related NICE guidance including falls prevention.
SH	Chartered Society of Physiotherapy (CSP)	19.07	Full	41	28	Very pleased to see research emphasis on people in care homes, and totally agree with the rationale behind this point. Many are denied the same level of rehabilitation as those who are community dwelling.	Thank you for your comment
SH	Chartered Society of Physiotherapy (CSP)	19.08	Full	135	2	Glad to see that this is a key priority for implementation –as changes in service delivery may also be required in order to obtain this on a 7/7 model of care, with budget implications, can the 'other considerations' have greater emphasis	Thank you for your comment. After careful consideration, we came to the conclusion that we do not agree. This recommendation is a key priority for implementation and NICE will be publishing implementation tools shortly after the publication of this Guideline which we hope will help with this matter.

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SH	Chartered Society of Physiotherapy (CSP)	19.09	Full	140	1	There is no clarification about whether 1x day mobilisation recommendation is for inpatient stay only? Implied as outcomes are length of hospital stay. There is also implication that as evidence doesn't fully support all other interventions that physiotherapy will become reduced to 'walking' only. Can there be a good practice guide that highlights the section in 'Other considerations' which does state that patients might benefit from more intensive rehabilitation? On page 132, line 25 it states that usual physiotherapy care includes walking aids, gait re-education and bed exercises – it would be useful to repeat this here to reduce the risk of physiotherapy intervention being seen as just walking.	Thank you for your comment. Yes the daily mobilisation is for inpatient stay. The GDG did not intend physiotherapy to be interpreted as 'walking only'. However, the evidence presented was of low quality and low sample size, therefore the GDG was unable to recommend detailed physiotherapy interventions. Hence the issue is one of professional judgement as we have no evidence to guide us any further. The linking evidence to recommendation has been updated to emphasize this.
SH	Chartered Society of Physiotherapy (CSP)	19.10	Full	170	21	The evidence statement is clear that functional outcomes are improved in ESD. However, this clear benefit of ESD is not then highlighted in the following recommendations on 171, 1.	Thank you for your comment. We agree and the following text has been added to the 'trade off between clinical benefits and harms' in section 12.4.4: The evidence reviewed showed an increase in functional independence measures with ESD compared to usual care.
SH	Chartered Society of Physiotherapy (CSP)	19.11	Full	172	1	As the studies only included cognitively intact patients, can you exclude cognitively impaired patients from the recommendation? What criteria are used to determine whether someone is cognitively intact? It is mentioned in other considerations, so why put it as an exclusion in the recommendation?	Thank you for your comment. We agree and have amended the recommendation so that the second bullet point reads: • has the mental ability to participate in continued rehabilitation The GDG based this wording on the paper from Crotty et al.,{CROTTY2003}, in which

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							cognitively intact was defined as 'patients who have the mental capacity to participate in a rehabilitation programme'. In addition the GDG were reluctant to define cognitive impairment based on a score, recognising the fact the cognition fluctuates and that rehabilitation goals need to be set individually by the multidisciplinary team. Diagnosis of dementia is covered in the NICE dementia guidelines (www.nice.org.uk/guidance/CG42) and delirium in the NICE delirium guidelines (www.nice.org.uk/guidance/CG103).
SH	Chartered Society of Physiotherapy (CSP)	19.12	Full	173	1	More emphasis required on patients going back to care home still being under the HFP and **receiving the same level of rehabilitation**. In many areas physiotherapy support to care home settings is extremely patchy and couldn't sustain input required with present levels of staffing	Thank you for your comment. We agree. We have added more detail to the linking evidence to this recommendation, under trade-offs between clinical benefits and harms: Provision of part of a patient's continuing rehabilitation programme in the care or nursing home of origin is correctly categorised as either early supported discharge or intermediate care, and the continued involvement of the Hip Fracture Programme team in liaison with the community-based component is therefore correspondingly a requirement.

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SH	**Chartered Society of Physiotherapy (CSP)**	**19.13**	**Full**	**175**	**1**	The points highlighted in this section are really important – care home residents are likely to miss out on targeted rehabilitation due to a lack of research in this area and a lack of resources provided for this population even though they are likely to be frailer, have more co morbidities, and are likely to be looked after by the least skilled workforce.	Thank you for your comment.
SH	Chartered Society of Physiotherapy (CSP)	19.14	NICE	13	1.8.5	The GDG need to consider **how** the acute sector is to agree on length of stay as this will depend on how the patient progresses with rehabilitation in intermediate care. The acute sector will not be able to monitor this once the patient has been discharged. This should surely be led by the intermediate care team.	Thank you for your comment. We have now clarified the continuing governance responsibilities of the Hip Fracture Programme Team and have amended the second and third bullet points of this recommendation to give greater clarity: 'the Hip Fracture Programme team leads clinically: on patient selection, and in agreeing length of stay and objectives for intermediate care the Hip Fracture Programme team leads managerially: ensuring that intermediate care is not resourced at the expense of the acute hospital's multidisciplinary team.' We agree, however, that effective liaison will be essential.

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SH	Chartered Society of Physiotherapy (CSP)	19.15	NICE	13	1.8.4 & 1.8.5	Early supported discharge may only be possible for patients who live locally to the Trust they are admitted to - a significant percentage of patients may live a considerable distance from the hospital.	Thank you for your comment. We agree that these logistic issues will be part of the decision-making process, although the availability of competent community-based support and close liaison with the Hip Fracture Programme team may be more important than geographical distance per se. This is a local implementation issue. NICE will be publishing implementation tools shortly after the publication of this Guideline which we hope will help with this matter.
SH	Chartered Society of Physiotherapy (CSP)	19.16	Full	General		Please pass on our thanks to members of the GDG for the time and effort they have contributed to the development of the guideline.	Thank you for your comment.
SH	Department of Health	20.00		General		Overall, we are highly supportive of this guidance, and particularly impressed by the carefully derived content.	Thank you for your comment.

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SH	Department of Health	20.01	Press release	2	N/A	In our view, the paragraph relating to 'surgical procedures' is confusing for practicing clinicians who do not use the ICD10 language in normal practice. The surgical options are internal fixation or arthroplasty. We feel that joint reconstruction is not a useful term in this context. Within arthroplasty, there is either hemiarthroplasty or total hip arthroplasty.	Thank you for your comment, We will refer this to the NICE communications team as they are responsible for the press releases. This consultation is about the text and content of the guideline.
SH	Department of Health	20.02	Short version	4	N/A	The document by its content (orthogeriatrician, co-morbidities, mortality rate etc) assumes older people with a fragility fracture; indeed that is the patient group the guidelines are aimed at. In our opinion, the stating of an average age of 77 is either incorrect or includes young patients with non-fragility hip fractures. UK datasets indicate an average age of 83 to 84 years. Perhaps a median could be the best average to describe the cohort distribution.	Thank you for your comment. We have updated accordingly.
SH	Department of Health	20.03	Short version	7	N/A	Under the heading 'Surgical procedures,' for total hip replacement, study entry criteria and previous THA assessment suggest the mobility criteria should be 'independently mobile out of doors with the use of no more than a stick.' We consider that the current wording appears to suggest offered to patients able to walk short distance indoors only with a frame are included. We do not believe that there is evidence for this.	Thank you for the comment. We have amended the recommendation to state this.

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SH	Department of Health	20.04	Short version	8	N/A	Under the heading 'multidisciplinary management,' we would have expected, from admission, a specific inclusion of senior anaesthetic input.	Thank you for your comment. After careful consideration, we came to the conclusion that we do not agree. Competent anaesthetic (alongside medical and surgical) input is incorporated (and reasonably assumed) within the recommendation "rapid optimisation of fitness for surgery" as part of the Hip Fracture Programme. Anaesthetist seniority is now covered within a revised recommendation on surgeon seniority.
SH	Department of Health	20.05	Short version	11	N/A	In paragraph 1.4.2, we are assuming that this only applies to patients from 1.4.1, who decide on General anaesthesia (and not ALL patients as stated).	Thank you for your comment. Yes we do mean all patients including those who have spinal anaesthesia as the analgesia from nerve blocks lasts longer than the analgesia from the spinal procedure. We have amended the text to make the rationale for the recommendation more explicit.
SH	Department of Health	20.06	Short version	11	N/A	In paragraph 1.6.3,for total hip replacement, study entry criteria and previous HTA assessment suggest the mobility criteria should be 'independently mobile out of doors with the use of no more than a stick.' In our view, the current wording seems to suggest that THA be offered to patients able to walk short distance indoors only with a frame are included; We do not believe that there is evidence for this.	Thank you for the comment. We have amended the recommendation to state this.

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SH	RCGP	21.00	Full Guidelines	7 Page 6 Page 7	1-10	Very useful complemented by a useful diagram on page 9 (could this diagram go in the condensed guidelines? General Comments: 1. Welcome the patient centred approach Specialist input sounds sensible	Thank you for your comment. NICE produce the condensed version simply as a summary of the recommendations from the full version. Therefore, this does not normally include any evidence, tables, charts or any other background/explanatory information which are in the full version.
SH	RCGP	21.01	Guidelines	Page 6		Welcome the patient centred approach	Thank you for your comment.
SH	RCGP	21.02		Page 7		Specialist assessment sounds sensible	Thank you for your comment.

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SH	RCGP	21.03		Page 8		I like the orthogeraitric approach and hope this is implemented across all trusts	Thank you for your comment.
SH	RCGP	21.04		Page 9		Surgery on the day or the day after admission is important for the relatives and patient alike	Thank you for your comment.
SH	RCGP	21.05		Page 10		Commendable that the guidelines indicate that pain should be assessed after 30minutes	Thank you for your comment.
SH	RCGP	21.06		Page 12		Multidisciplinary approach important and excellent that this is explicitly stated	Thank you for your comment

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SH	RCGP	21.07		13		The principle of early supported discharge is vital, especially the emphasis on *supported e.g intermediate care*	Thank you for your comment
SH	RCGP	21.08		14		Stressing that the same level of rehab should be applied to care home or nursing home residents is excellent	Thank you for your comment
SH	RCGP	21.09		General		I thought the guidelines were clear, succinct and with some very good recommendations. If all these are implemented then the quality of care will only improve for these patients. My local experience is that the discharge information is comprehensive and that the rehab programme works for most We have a local dedicated orthopaedic centre with an excellent reputation. Within the discharge summary it would be useful for GPs to be informed when patients should be re-referred in the event of post op complications. It may be that most patients are informed.	Thank you for your comment. We have amended recommendation 1.8.5 to give greater emphasis to the importance of close communication and working between the Hip Fracture Programme, primary care and other services.

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SH	NETSCC, HTA ref 1	22.00	Full	General	General	**1.1 Are there any important ways in which the work has not fulfilled the declared intentions of the NICE guideline (compared to its scope – attached)** It seems comprehensive but I am not a subject matter specialist.	Thank you for your comment.
SH	NETSCC, HTA ref 1	22.01	Full	General	General	**2.1 Please comment on the validity of the work i.e. the quality of the methods and their application (the methods should comply with NICE's Guidelines Manual available at http://www.nice.org.uk/page.aspx?o=guidelinesmanual).** I have grouped these under statistical issues in section 2.2	Thank you for your comment.
SH	NETSCC, HTA ref 1	22.02	Full	20	3.2.1	**2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** I know this is the HTA standard choice but I do question the wisdom of restricting to articles written in English particularly when there are so few available.	Thank you for your comment. We are aware that there is the potential for publication bias by excluding non-English articles. We do not have the resources to translate non-English articles and consequently take a systematic approach to all our guidelines on not including these. Wherever possible we will use translations of articles. Also, in this guideline we have used Cochrane reviews for some questions. These generally include foreign language articles which we would also include based on their data.

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SH	NETSCC, HTA ref 1	22.03	Full	22		Confidence intervals for I^2 would be helpful to give us some indication of the uncertainty of estimation of this quantity. With typical numbers of studies I imagine it is very imprecisely estimated.	We have based our assessment of heterogeneity on I squared, the p value for the chi squared test and looking at the forest plots.
SH	NETSCC, HTA ref 1	22.04	Full	27	3.3.8	Need to explain the choice of confidence interval (0.75 and 1.25) better. What units is this in? It is not really sufficient just to refer to the software default. I could not find any intellectual justification for this choice on the software website.	The values relate to relative risk values and therefore there are no units. We have amended the text to make this clear. The confidence intervals of 0.75 and 1.25 around the relative risk are recommended defaults devised by the GRADE Working Group (http://www.gradeworkinggroup.org/). More information is given in the software by clicking on "Help" and searching on "Imprecision".
SH	NETSCC, HTA ref 1	22.05	Full	56	6.1.1.1	What do footnotes (a) and (b) mean? They are really cryptic. Footnote (e) and its equivalent in the other tables seems completely unnecessary as we have already been told what imprecision means	Thank you for your comment. Footnotes (a) and (b) refer to the baseline characteristics such as patient age. Footnote (a) refers to Bottle and Aylin 2006, which provides medians for the whole cohort and also stratified by type of surgery e.g. fixation, replacement, other procedure. Footnote (b) refers to this data being stratified by hospital. Both of these are highlighted as they do not stratify the data by delay to surgery, but do provide adjusted odd ratios for these. This has been made more explicit in the footnotes: (a) *In Bottle and Aylin, 2006 [30] baseline data, such as age is given for the entire cohort and also stratified by type of surgery e.g. fixation,*

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							replacement, other procedure. No baseline data stratified by delay to surgery. Patients were all admitted from their own home. *(b) In Weller et al., 2005[342] baseline data, such as age is stratified per hospital. No baseline data stratified by delay to surgery.*
SH	NETSCC, HTA ref 1	22.06	Full	57	Table 6-11	Clarify here and elsewhere that these are the total N. Note however that many other tables (eg Table 7–25) have the fraction. Can all the mortality not be combined perhaps with a meta–regression including a term for time interval?	Thank you for your comment. Data is given for adjusted odds ratios with numbers of patients given in each study arm. No event numbers are given as the data has been adjusted using logistic regression for confounding factors. A table footnote explaining this has been added: *(a) Numbers of patients in each study arm. No event data is given as the data provided is odds ratios adjusted using logistic regression for confounding factors.* Meta-regression is not considered appropriate in this case as there are fewer than 10 included studies. We follow the Cochrane methodology for meta regression and their hand book states that: "Meta-regression should generally not be considered when there are fewer than ten studies in a meta-analysis" Section 9.6.4

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SH	NETSCC, HTA ref 1	22.07	Full	72	Table 7-25	Why RR here whereas OR elsewhere?	Thank you for your comment. We have used RR as standard throughout the document except for some cases such as timing of surgery as the studies are observational studies where the data is given for adjusted odds ratios with numbers of patients given in each study arm. No event numbers are given as the data has been adjusted using logistic regression for confounding factors. This adjusted data is therefore presented as the paper reported it; as adjusted odds ratios.
SH	NETSCC, HTA ref 1	22.08	Full	85	8.2.1.3	Refers to mortality combined but this is not in Table 8-27. The relevant time periods, 1, 3, 6 and 12 months seems to call for a meta–regression again.	Thank you for your comment. The evidence statement is incorrect as we didn't actually combine all the studies. The forest plot was just a visual representation of the results to make it easier for the GDG to interpret. In fact there was no need to look at mortality beyond 1 month as all other time points were not included in our main outcomes of interest. Therefore, we have deleted the evidence statement and related forest plot.
SH	NETSCC, HTA ref 1	22.09	Full	89	9.2.2	Four cohorts are referred to here but there are only two, or possibly three, in Table 9–30	Thank you for your comment. We have amended this to state three cohort studies.

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SH	NETSCC, HTA ref 1	22.10	Full	96	10.3.1.2	Can all the mortality results not be combined? Why does footnote (a) also appear as serious imprecision? Is this really a source of imprecision?	Thank you for your comment. The follow up periods for mortality were considered to be different which is why they have been treated as different outcomes. Also, it is the same studies with mortality at different time points. Therefore the data cannot be combined. Thank you for pointing out the error in the footnote. The result with (a) marked in the precision column should be (b). We have corrected this.
SH	NETSCC, HTA ref 1	22.11	Full	133	Table 11-57	Is independent to step the wrong way round? As presented it goes in the opposite direction from independent to transfer.	Thank you for your comment. The data presented in table 11-57 is correct and does show an increased independence to transfer, but no increase in independence to step at 7 days with early ambulation compared to the control. The limitations of this data were highlighted to the GDG and discussed in the quality of evidence section of the recommendation. However, there is an error in the evidence statement and relative values of different outcomes in the linking evidence to recommendations section which have been amended.
SH	NETSCC, HTA ref 1	22.12	Full	Forest plots		I give below a selection of the problems I have found with the forest plots in Appendix D. I must emphasise that this is merely a selection and I could have multiplied the instances if I had had the time and patience.	Thank you for your comment. We have responded to these specific comments individually. We would like to note however that cohort studies have not been meta analysed and have been presented in forest plots without summary statistics.

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SH	NETSCC, HTA ref 1	22.13	Full	454	Plot G-15	The choice behind these seems really bizarre. In many cases the meta–analysis summary is presented only for those plots with only one estimate, where it is redundant, but not for examples where there are several studies. For instance I do not see why G-15 with its three studies cannot be meta–analysed. If we do we find an overall estimate on the log odds scale of 0.47 (0.23 to 0.71). I used a fixed effect estimate as that is what G–15 says was done, there is substantial heterogeneity although with only three studies it will be very poorly estimated. (Page 22 seems to suggest a random effects model would have been used here.) Table 6–14 assures us there is no serious inconsistency which is not what my analysis shows. Table 6–15 shows the three studies separately but section 6.1.1.3 seems to suggest that an overall meta–analysis was carried out. Later on for some reason we do get summary statistics.	Thank you for your comment. Meta-analysis summaries are provided for those studies that can be combined e.g. RCTs. No summary is provided for studies that are inappropriate to be combined, such as cohort studies. The individual studies are likely to be subject to confounding and bias, so that effects reported may differ from the true underlying effects in ways that are systematically different from chance. Combining such studies will increase the precision of an inaccurate result and may lead to inappropriate conclusions. G15 displays three studies with the outcome of pressure ulcers. These studies are all cohort studies adjusted for confounding factors using logistic regression and are inappropriate to combine.
SH	NETSCC, HTA ref 1	22.14	Full	456	Plot g-22	Many of the plots are just wrong, for instance G–22 the confidence interval for the single study is much wider than for the summary which cannot be correct.	Thank you for your comment. This is a software issue and has been corrected. The risk ratio and confidence intervals are correctly stated in the table, but the diamond in the forest plot did not match up.

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SH	NETSCC, HTA ref 1	22.15	Full	482	Plot G-76	G–76 has an overall summary but in the light of the heterogeneity perhaps should have meta–regression.	Thank you for your comment. There were more subgroups identified by the GDG that could cause heterogeneity for this analysis. These include the use of cement or the type of patients (i.e. 'younger, fitter patients' compared to older patients with comorbidities). To do a meta-regression for this would require more studies than we have available for the analysis.
SH	NETSCC, HTA ref 1	22.16	Full	General	General	**3.1 How far are the recommendations based on the findings? Are they a) justified i.e. not overstated or understated given the evidence? b) Complete? i.e. are all the important aspects of the evidence reflected?** **3.2 Are any important limitations of the evidence clearly described and discussed?** **4.1 Is the whole report readable and well presented? Please comment on the overall style and whether, for example, it is easy to understand how the recommendations have been reached from the evidence.** The recommendations include sample size suggestions but no evidence to justify them. This gives them a rather back of the envelope feel.	The sample sizes are estimates by the GDG to give a rough indication of the number of patients that would be required. They are not meant to be an accurate reflection of the number of patients required for each outcome. A more rigorous calculation will be done if this recommendation is to be prioritised for funding.
SH	NETSCC, HTA ref 2	22.17	Full	12/13	20 - 09	**1.1 Are there any important ways in which the work has not fulfilled the declared intentions of the NICE guideline (compared to its scope – attached)** Key indicators set out in page 8 lines 19-39 show a need for communication with patients, their representatives to promote expectations of a	The section on page 8 of the introduction is describing the GDG's perception of the current position and is not meant to indicate what is included in the guideline. It highlights the importance of multi-disciplinary management which we believe we have covered in the guideline.

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						successful outcome. This is not clearly set out in the development of guideline for 'key clinical areas', so may not have the influence required for rehabilitation.	
SH	NETSCC, HTA ref 2	22.18		26/27		**2.1 Please comment on the validity of the work i.e. the quality of the methods and their application (the methods should comply with NICE's Guidelines Manual available at http://www.nice.org.uk/page.aspx?o=guidelinesmanual).** Equivalence studies could have been included.	Thank you for your comment. We did not exclude equivalence studies. Any study meeting the inclusion criteria, were included if retrieved.
SH	NETSCC, HTA ref 2	22.19		33	8/9	Although reference is made to category 'F' later in the key priorities for implementation, there is no 'F' item	Thank you for your comment. We agree the text 'Mean patients reach critical points in the care pathway more quickly (F)' has been added to the relevant section.
SH	NETSCC, HTA ref 2	22.20		34	26	A list of alphabet gives the programme but 'F' is missing	Thank you for your comment. We agree and have removed the duplicate text '(A,B,C,D,E,F,W,X,Y and Z).

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SH	NETSCC, HTA ref 2	22.21		34	26-32	Patients should aim to be independent for most/all of activities of daily living	Thank you for your comment. The GDG identified this as a core objective in the recommendations on multidisciplinary rehabilitation. However, it is not an evidence-based selection criterion for early supported discharge.
SH	NETSCC, HTA ref 2	22.22	Full	35	2	Patients should not have to return to care for partner in home but have a Social Services Assessment.	We have found this comment difficult to understand as the page and line number refer to a blank line, before that is the recommendation relating to early supportive discharge. We regret we are unable to provide a response.
SH	NETSCC, HTA ref 2	22.23	Full	77/78/79		**2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** Analgesia is discussed in terms of first-fall back treatment. Applied to economic cost of procedures this is a sound basis for decisions.	Thank you for your comment.
SH	NETSCC, HTA ref 2	22.30	Full	General	General	**4.2 Please comment on whether the research recommendations, if included, are clear and justified.** All recommendations where given are clear and linked to the discussion and evidence supplied	Thank you for your comment.

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SH	NETSCC, HTA ref 2	22.31	Full	General	General	**Section five – additional comments** **Please make any additional comments you want the NICE Guideline Development Group to see, feel free to use as much or as little space as you wish.** Have provided some issues not included as listed above	Thank you for your comment.
SH	British Geriatrics Society, British Orthopaedic Association and National Hip Fracture Database	23.00	Full	General		The recommendations for the expansion of the Hip Fracture Programme Multidisciplinary Team into the supervision of rehabilitation across differing health and potentially social care settings both clinically and managerially would be impractical in many areas of the country due to many differing health care providers serving the same acute trust.	Thank you for your comment. After careful consideration, we came to the conclusion that we do not agree that this should be changed. We think it is important to state that it may be challenging for the different agencies involved to collaborate in providing, funding, auditing and managing a patient centred pathway for care and rehabilitation - from hospital into community and care home - but this is a key aspect of this Guideline's focus on the Hip Fracture Programme as central to the whole hip fracture pathway. Not least, the guidance should act as a driver for the committed orthogeriatrician and HFP team to retrieve the unsatisfactory situation you describe in the interests of better clinical and service governance, continuity and quality of patient care.

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SH	British Geriatrics Society, British Orthopaedic Association and National Hip Fracture Database	23.01	Full	General		While there is reference to the NICE guidelines on delirium there is no reference to the guidelines on Falls or Osteoporosis in the care and assessment of hip fracture patients. These important guidelines for the group of patients should be referenced rather than assumed.	Thank you. We have added an additional statement at the beginning of the full list of recommendations which gives greater emphasis to the importance of management in accordance with existing NICE guidance which may be relevant to hip fracture. .
SH	British Geriatrics Society, British Orthopaedic Association and National Hip Fracture Database	23.02	Full	General		At present there are other national guidelines regarding the care of hip fracture patients, which best practice tariff standards are based but are at some variance with this guideline. Will there be clarification as to the guidelines to be used and any changes in the best practice tariff standards?	Thank you for your comment. Although NICE Guidance is commissioned by the Department of Health and are developed within a known context, they are entirely independent and free-standing,
SH	British Geriatrics Society, British Orthopaedic Association and National Hip Fracture Database	23.03	NICE Guideline: draft for consultation, Oct. 2010	General		General • The three stakeholders here responding jointly to the consultation – the BOA, the BGS, and the NHFD – are committed to the improvement of hip fracture care: as the two professional societies representing the clinical specialties most involved; and as an established national audit of hip fracture care – itself a collaborative venture initiated by BOA and BGS • This guideline is a welcome addition to the body of knowledge now supporting improvements in the care of patients with hip fracture	Thank you for these comments. The phraseology of clinical guidelines is required to be consistent. However, we have adjusted the wording where possible to reflect those differing situations where the dynamic is weighted more in the direction of either patient choice or professional recommendation.

Comment [SF1]: May require input from NICE

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						• In General terms, however, it confirms rather than transforms current guidance on hip fracture care • The emphasis on the importance of collaborative working between orthopaedic surgeons and geriatricians is to be commended – with the growth of such collaboration in recent years a major factor in the improvement of care • The guideline's limitations – like those of preceding guidelines – are a reflection mainly of the limited volume of high-quality evidence concerning some aspects of care Research • The research recommendations (pages 15-19) are therefore of special interest; and the three stakeholders jointly responding strongly support the research agenda that emerges • In particular, the large-scale studies recommended – on anaesthetic practice; surgery for displaced intracapsular hip fracture; rehabilitation practice; and early supported discharge – might best be addressed in the context of the National Hip Fracture Database, with its comprehensive coverage of hip fracture care in England, Wales and Northern Ireland and its detailed and rapidly growing and database – which now	

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						includes more than 100,000 cases. • The necessary studies – with access to the rapid case recruitment and outcome data, and to the case-mix adjustment that NHFD provides (a matter not sufficiently emphasised in the document) – could, subject to funding, be addressed fairly quickly and effectively using the existing NHFD infrastructure. Professional recommendation or patient choice? • This is clearly a sensitive matter. Previous relevant guidelines have focussed on providing advice for clinicians, with recommendations to them that are based on relevant evidence; whereas the frequent use of the term 'offer' in the draft for consultation could be seen as supporting a retreat from appropriate professional responsibility for making decisions on behalf of patients, many of whom might quite reasonably experience extreme difficulty in choosing – e.g. between spinal and General anaesthetic or between cemented and un-cemented arthroplasty – even after the provision of detailed and specific information by the responsible clinician. • In the potentially distressing circumstances of pre-operative hip fracture care, routinely imposing upon vulnerable and perhaps confused	

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						patients the burden of fully informed choice might prove to be simply impractical. • However, good professional practice and communication – including all appropriate explanation, support and discussion with patients and their relatives – is established practice, and entirely consistent with the provision of professionally led and evidence-based care. • If the guideline indeed sets out to steer hip fracture care in the direction of evidence-based best practice, the current emphasis on patient choice may serve only to obscure that important goal. • Where the evidence base is less than perfect, relevant decision-making might reasonably be seen as a professional responsibility – subject of course to communication and discussion – rather than one to be routinely delegated to hip fracture patients in circumstances already, for most, probably uncertain and stressful enough.	

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SH	British Geriatrics Society, British Orthopaedic Association and National Hip Fracture Database	23.04	As above	4	28	The quoted average age at hip fracture of 77 is surprising; the 2010 NHFD National Report (c. 36,500 cases) shows average age for males to be 83, and for females 84	Thank you. We have adjusted the narrative accordingly.
SH	British Geriatrics Society, British Orthopaedic Association and National Hip Fracture Database	23.05	As above	8	17	The restriction of early supported discharge services exclusively to patients with 'no cognitive impairment' is controversial. No evidence is cited in the full guideline, and this recommendation is in conflict with current DH guidance on Intermediate Care (Halfway Home, DH, 2009) on inclusion of patients with cognitive impairment in community based programmes.	Thank you for your comment. We agree and have amended the recommendation so that the second bullet point reads: • has the mental ability to participate in continued rehabilitation The GDG based this wording on the paper from Crotty et al.,{CROTTY2003}, in which cognitively intact was defined as 'patients who have the mental capacity to participate in a rehabilitation programme'. In addition the GDG were reluctant to define cognitive impairment based on a score, recognising the fact the cognition fluctuates and that rehabilitation goals need to be set individually by the multidisciplinary team. Diagnosis of dementia is covered in the NICE dementia guidelines (www.nice.org.uk/guidance/CG42) and delirium in the NICE delirium guidelines (www.nice.org.uk/guidance/CG103).

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SH	National Osteoporosis Society	24.00		General		We welcome the guideline which makes clear recommendations about the management of hip fractures and includes orthogeriatric input, multidisciplinary team working and linking with primary care.	Thank you for your comment.
SH	National Osteoporosis Society	24.01	Full	143	14	We accept that osteoporosis is not included in the scope of the guideline. However, the full guideline acknowledges that hip fracture occurs most commonly in patients with osteoporosis or osteopenia, and that osteoporosis and falls are covered in separate NICE guidance. An explicit reference should be made on the need for bone health and falls assessment in patients with hip fracture to reduce risk of future fractures. This should refer readers to relevant NICE guidance: TA161 for secondary prevention of osteoporosis, TA204 on osteoporotic fractures: Denosumab, CG21 on falls and the forthcoming short clinical guideline on osteoporosis (in development).	Thank you. We have added an additional statement on page 9 of the NICE version and at the beginning of the full list of recommendations in the full version to refer clinicians to other guidance giving greater emphasis to the importance of management in accordance with existing NICE guidance, including the Technology Appraisals and Clinical Guidelines to which you refer.
SH	National Osteoporosis Society	24.02	NICE guideline	General		While the full guideline makes several references to bone health and falls, this is not reflected in the NICE guideline. An explicit reference should also be made in the NICE guideline on the need for bone health and falls assessment in patients with hip fracture to reduce risk of future fractures. This should refer readers to relevant NICE guidance: TA161 for secondary prevention of	Thank you. We have added an additional statement on page 9 of the NICE version and at the beginning of the full list of recommendations in the full version to refer clinicians to other guidance giving greater emphasis to the importance of management in accordance with existing NICE guidance, including the existing Technology Appraisals and Clinical Guidelines to which you refer.

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						osteoporosis, TA204 on osteoporotic fractures: Denosumab, CG21 on falls and the forthcoming short clinical guideline on osteoporosis (in development).	
SH	National Osteoporosis Society	24.03	NICE guideline	General		Recommendations align with the criteria for achieving best practice tariff for hip fracture with regard to orthogeriatric input and time to surgery, while bone health is omitted. We would welcome a statement as per our comment above to give consistent messages about the importance of bone health assessment in this patient group.	Thank you. We are aware of, and have referred in the introduction to, the contemporary context. NICE Guidance is, however, independent of concurrent initiatives.
SH	National Osteoporosis Society	24.04	NICE guideline	General		30% of hip fracture patients are men; there is not a TA on male osteoporosis, therefore what should be done for secondary prevention for men?	Thank you for your comment. Secondary prevention was outside the scope of this guideline.
SH	National Osteoporosis Society	24.05	NICE guideline	General		No guidance from NICE on the use of zoledronic acid for secondary prevention	Thank you for your comment. Secondary prevention was outside the scope of this guideline.

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SH	National Osteoporosis Society	24.06	Full/NICE guideline	General		The scope state that this guideline does not cover nutritional support. However, there is evidence that hip fracture patients have low protein intakes and they could be deficient in other nutrients. They are likely to become vitamin D deficient as a result of the hip fracture causing reduced mobility. Recommendations should include reference to the importance of adequate dietary protein intake, dietary calcium intake (which should include considering supplements if inadequate) and consideration of vitamin D supplementation. The diet should be a balanced one as other vitamins and nutrients are important for good bone health and with recovery. An explicit reference should be made to NICE guidance on Nutrition support in adults.	Thank you. We have added an additional statement on page 9 of the NICE version and at the beginning of the full list of recommendations in the full version to refer clinicians to other guidance giving greater emphasis to the importance of management in accordance with existing NICE guidance.
SH	National Osteoporosis Society	24.07	NICE guideline	8		No details are provided about what an orthogeriatric assessment should include.	Thank you for your comment. The Comprehensive Assessment that would be provided to individual patients by a multidisciplinary HFP team will vary according to individual circumstances, and it was not felt appropriate to specify these in detail in this Guideline. This has been added to the other considerations for this recommendation in the full guideline.

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SH	National Osteoporosis Society	24.08	NICE guideline	9		Paragraph 1.3.1: Has inclusion of analgesia as part of the ambulance call out been considered?	Thank you for your comment. Analgesia as part of the ambulance call out falls outside the scope of this guideline.
SH	National Osteoporosis Society	24.09	NICE guideline	12		Paragraph 1.7.2: A minimum acceptable physiotherapy review standard should be given, i.e. at least 30 minutes per person.	Thank you for your comment. After careful consideration, we came to the conclusion that we do not agree that this should be changed. There is insufficient evidence to suggest what the exact dosing of physiotherapy should be, and this will vary according to the physical capabilities of each patient - those who are very ill will not tolerate as much physical activity as those who are progressing well. Each person should be seen each day by a physiotherapist or the designate for mobilisation, and that this should be initiated as soon after surgery as possible, as stated in recommendations 1.7.1 and 1.7.2. We have indicated that the dosing should be based on a physiotherapist assessment. Hence the issue is one of professional judgement as we have no evidence to guide us any further. However, an additional observation is that the principles of management should not be any different for people with dementia, than those without.

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							In addition, the physiotherapy review should be part of the continued co-ordinated orthogeriatric and multidisciplinary review as stated in the recommendation 1.8.1 regarding a Hip Fracture Programme. The linking evidence to recommendation has been updated to emphasize this.
SH	National Osteoporosis Society	24.10	NICE guideline	12		Paragraph 1.8.1: Social services should be included within multidisciplinary management	Thank you for your comment. After careful consideration, we came to the conclusion that we do not agree. We think that this is adequately covered in the full version of the guideline as it states that social services are a core component of multidisciplinary rehabilitation team (section 2.2)
SH	National Osteoporosis Society	24.11	NICE guideline	13		Paragraph 1.8.4: How is no cognitive impairment defined?	Thank you for your comment. We agree and have amended the recommendation so that the second bullet point reads: • has the mental ability to participate in continued rehabilitation The GDG based this wording on the paper from Crotty et al.,{CROTTY2003}, in which cognitively intact was defined as 'patients who have the mental capacity to participate in a rehabilitation programme'. In addition the GDG were reluctant to define cognitive impairment based on a score, recognising the fact the cognition fluctuates and that rehabilitation goals need to be set individually by the multidisciplinary team.

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							Diagnosis of dementia is covered in the NICE dementia guidelines (www.nice.org.uk/guidance/CG42) and delirium in the NICE delirium guidelines (www.nice.org.uk/guidance/CG103).
SH	National Osteoporosis Society	24.12	NICE guideline	14		Paragraph 1.9.1: Patient information should also include information about falls, bone health and secondary prevention of fractures.	Thank you for your comment. The scope of the guideline excludes these areas therefore we have not made any recommendations on them. Please note, we wrote the recommendation so that the list should be read as a minimum of elements to include, rather than a complete one. It does not preclude healthcare professionals from adding items to their written and verbal information. There is already NICE guidance concerning falls. We have amended the section linking the evidence and recommendation in the full version of the guideline (13.3.2) to cross refer to the falls guidelines.
SH	JRI Orthopaedics	25.00	FULL	40	4	Further research should be conducted on a comparison between cemented and HA Coated Hemiarthroplasty stems NOT uncemented non-coated stems.	Thank you for your comment. The list of research recommendations in this chapter relate to suggested studies that the GDG thought should be prioritised for research. Although an important question the GDG did not prioritise a research recommendation relating to cemented arthroplasties.

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SH	JRI Orthopaedics	25.01	FULL	109	1	The ability to correctly trial the acetabular component should be available to the Operating Surgeon at all times to ensure an optimum anatomical patient fit.	We have not included details on specific techniques as it is outside the scope of this guideline.
SH	JRI Orthopaedics	25.02	FULL	109	1	Modularity of the femoral stem i.e. a good range of sizes ensures close matching of the patients' anatomy and an optimal cement mantle.	We have not included details on specific techniques as it is outside the scope of this guideline.
SH	JRI Orthopaedics	25.03	FULL	111	5	1mm increments on the large metal head should be used to ensure an optimum anatomical patient fit.	Thank you for your comment. The GDG consider this suggestion too detailed for the scope of this guideline.
SH	JRI Orthopaedics	25.04	FULL	112	2	Correct placement of the femoral stem in the cement mantle of a correctly prepared femoral canal is obtained with easy to use accurate instrumentation allied to the prosthesis being used. The use of third party instrumentation should be discouraged.	This section is a brief introduction to the review question and is not meant to be a guide on how to perform surgery. We have not included details on specific techniques as it is outside the scope of this guideline.

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SH	JRI Orthopaedics	25.05	FULL	112	2	If cement is used then this should be allowed to fully cure before the introduction of the large metal head, reducing the risk of mal-positioning of the implant.	This section is a brief introduction to the review question and is not meant to be a guide on how to perform surgery. We have not included details on specific techniques as it is outside the scope of this guideline.
SH	JRI Orthopaedics	25.06	FULL	118	10.4.3	Clinical evidence relating to the clinical and health economic performance of HA coated Hemiarthroplasty stems should be sought and researched.	Although an important question the GDG did not prioritise this as a research recommendation.
SH	Royal College of Nursing	26.00	General			The Royal College of Nursing welcomes this guideline. It is comprehensive.	Thank you for your comment.
SH	Royal College of Nursing	26.01	Full	7	30	This should include elderly care input and mental health status assessment.	Thank you for your comment. This is a core component of orthogeriatric assessment, but we have now also made the linkage to mental health services more explicit by adding the following bullet point in recommendation 1.8.1: • liaison or integration with related services, particularly mental health, falls prevention, bone health, primary care and social services

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SH	Royal College of Nursing	26.02	Full	8	27	Surgery in the first 24 hours is recommended. *(United They Stand: Co-ordinating Care for Elderly Patients with Hip Fracture (Audit Commission Report 1995))*	Thank you for your comment. The GDG were aware of the audit commission report 'United they stand'. In addition this was considered for inclusion for the early versus late surgery review question; however it did not meet our inclusion criteria. The rationale for selecting our threshold for timing of surgery is explained in the linking evidence to recommendations section 6.1.2 on page 65.
SH	Royal College of Nursing	26.03	Full	34	15	What is regular physiotherapy? A minimum standard should be stated.	Thank you for your comment. After careful consideration, we came to the conclusion that we do not agree that this should be changed. There is insufficient evidence to suggest what the exact dosing of physiotherapy should be, and this will vary according to the physical capabilities of each patient - those who are very ill will not tolerate as much physical activity as those who are progressing well. Each person should be seen each day by a physiotherapist or the designate for mobilisation, and that this should be initiated as soon after surgery as possible, as stated in recommendations 1.7.1 and 1.7.2. We have indicated that the dosing should be based on a physiotherapist assessment. Hence the issue is one of professional judgement as we have no evidence to guide us any further. However, an additional observation is that the principles of management should not be any different for people with dementia, than those without.

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							In addition, the physiotherapy review should be part of the continued co-ordinated orthogeriatric and multidisciplinary review as stated in the recommendation 1.8.1 regarding a Hip Fracture Programme. The linking evidence to recommendation has been updated to emphasize this.
SH	Royal College of Nursing	26.04	Full	37	9	Same as above, a minimum standard should be stated.	Thank you for your comment. After careful consideration, we came to the conclusion that we do not agree that this should be changed. There is insufficient evidence to suggest what the exact dosing of physiotherapy should be, and this will vary according to the physical capabilities of each patient - those who are very ill will not tolerate as much physical activity as those who are progressing well. Each person should be seen each day by a physiotherapist or the designate for mobilisation, and that this should be initiated as soon after surgery as possible, as stated in recommendations 1.7.1 and 1.7.2. We have indicated that the dosing should be based on a physiotherapist assessment. Hence the issue is one of professional judgement as we have no evidence to guide us any further. However, an additional observation is that the principles of management should not be any different for people with dementia, than those without.

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							In addition, the physiotherapy review should be part of the continued co-ordinated orthogeriatric and multidisciplinary review as stated in the recommendation 1.8.1 regarding a Hip Fracture Programme. The linking evidence to recommendation has been updated to emphasize this.
SH	Royal College of Nursing	26.05	Full	38	16	This is crucial but how can this be monitored – also how feasible is it?	Thank you for your comment. We agree and have amended the recommendation so that the second bullet point reads: • has the mental ability to participate in continued rehabilitation The GDG based this wording on the paper from Crotty et al.,{CROTTY2003}, in which cognitively intact was defined as 'patients who have the mental capacity to participate in a rehabilitation programme'. In addition the GDG were reluctant to define cognitive impairment based on a score, recognising the fact the cognition fluctuates and that rehabilitation goals need to be set individually by the multidisciplinary team. Diagnosis of dementia is covered in the NICE dementia guidelines (www.nice.org.uk/guidance/CG42) and delirium in the NICE delirium guidelines (www.nice.org.uk/guidance/CG103).

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SH	Royal College of Nursing	26.06	Full	134	5	With training, nurses could do this in out of hours.	Thank you for your comments. We have now added the following paragraph to the "Other considerations" in section 11.2.2: "The GDG also noted that albeit the intervention should be overseen by physiotherapists it is also important for nurses to re-enforce and encourage patients' mobility at all other times, under the guidance of the physiotherapist."
SH	DePuy International Ltd & Johnson & Johnson Medical	27.00	FULL	110	3	**10.3.5.1 Large Head THR vs. hemiarthroplasty** We support the view which NICE has expressed, recommending further research into the relative benefits of using Large Diameter Heads in total hip replacement procedures. However there is an emerging evidence base supporting the use and demonstrating the relative benefits of using large diameter femoral heads which should be considered. One such example is demonstrated in the Barnett paper **(1),** that looks at large diameter femoral head uncemented THR to treat FNOF. This is a single arm, non comparative study, but does show that they had no reinterventions at 13.5 months and that reoperation, revision and infection rates were all 0%. They concluded that uncemented THR with large diameter heads can be used to successfully treat FNOF and reduce the risk of hip instability.	Thank you for your comment. To demonstrate the effectiveness of interventions we believe a properly conducted randomised controlled trial is required. Hence the prioritised research question

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						Although not all of the following references directly relate to FNOF, they all show the benefits of a larger femoral head to potentially reduce the risk of dislocation in hip arthroplasty; • Berry et al found that in THR, a larger femoral head diameter was associated with a lower long-term cumulative risk of dislocation. **(2)** • Similarly, Cuckler et al **(3)** found that the use of larger-diameter femoral heads appears to have the potential to substantially reduce the early risk of dislocation of the prosthetic hip arthroplasty and in a large, multicentre study; • Dowd et al found decreasing dislocation rates with increasing femoral head sizes**. (4)** • Based on the results of a retrospective review, Hummel et al recommend the use of larger femoral head sizes in patients undergoing revision hip arthroplasty. **(5)** *(1) Barnett A.J, Burston B.J et al. Large diameter femoral head uncemented THR to treat FNOF. Injury, Int. J. Care Injured 40 (2009) 752-755* *(2) Berry D, Van Knoch M et al.* EFFECT OF FEMORAL HEAD DIAMETER AND OPERATIVE APPROACH ON DISLOCATION RISK AFTER TOTAL HIP	

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						ARTHROPLASTY. THE JOURNAL OF BONE & JOINT SURGERY · JBJS.ORG VOLUME 87-A · NUMBER 11 · NOVEMBER 2005 (3) Cuckler J, Moore, D et al. Large Versus Small Femoral Heads in Metal-on-Metal Total Hip Arthroplasty. The Journal of Arthroplasty Vol. 19 No. 8 Suppl. 3 December 2004 (4) Dowd J Kindsfater K et al. LARGE FEMORAL HEADS CAN HELP REDUCE RISK OF DISLOCATION IN TOTAL HIP ARTHROPLASTY. The Journal of Arthroplasty Vol. 23 No. 2 February 2008. (5) Hummel M, Malkani A et al. Decreased Dislocation After Revision Total Hip Arthroplasty Using Larger Femoral Head Size and Posterior Capsular Repair. The Journal of Arthroplasty Vol. 24 No. 6 Suppl. 1 2009	
SH	DePuy International Ltd & Johnson & Johnson Medical	27.01	FULL	118	10	**10.4.3 Recommendation: Offer cementless implants to patients undergoing surgery with arthroplasty** (suggested addition to above recommendation: ....**except in centres where cementless technology is already established)** We would agree that as a starting point that hip fractures should be treated using cemented stems unless cementless training and competency is established within the centre. This was demonstrated by Barnett et	(We assume there is a typo here and you meant to write "Offer cemented implants to……" as is written in the guideline. We did not identify RCT evidence demonstrating the effectiveness of cementless stems and consequently only recommend cemented.

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						al. **(1)** in Taunton, a well established cementless centre, who found that uncemented THR in hip fracture patients was straightforward and easily learnt by surgeons. Although most of the surgery was done by trainees, the surgical time was only 68 minutes on average. (28% of cases performed by consultant grade, 56% by registrar grade and 16% were performed by an associate specialist). In contrast, Blomfeldt et al***. (6)*** reported that cemented Exeter hip replacements performed 100% by consultants for similar indications took an average of 102 mins. *(1): Barnett A.J, Burston B.J et al. Large diameter femoral head uncemented THR to treat FNOF. Injury, Int. J. Care Injured 40 (2009) 752-755* *(6): Blomfeldt R, Tornkvist H, Eriksson K, et al. A randomised controlled trial comparing bipolar hemiarthroplasty with THR for displaced intracapsular fractures of the femoral neck in elderly patients. JBJS Br 2007; 89-B:160-5.*	
SH	DePuy International Ltd & Johnson & Johnson Medical	27.02	FULL	118	10	**10.4.3 Recommendation: Offer cementless implants to patients undergoing surgery with arthroplasty** Considering comments within the 'economic evidence' section 10.4.2.3, (line 2, page 118) this recommendation is based on an assumption that cemented stems cost less than cementless ones. However, the implant	Thank you for your comment. We have now added a further section in appendix H (section 20.8) where we have conducted a cost analysis on the cemented stems vs. uncemented stems (new design). Please refer to that section for further details.

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						prices used in the analysis are based on prices found in the NHS supply catalogue 2010 for implants referred to in the paper by Figved et al 2009. However the choice of this implant as the cemented comparator is not appropriate for the UK and the isolation of the implant cost without factoring in cement and cement accessories does not robustly capture the full procedural costs. This should be rectified to ensure an unbiased comparison.**(7)** According to the report by the National Joint Registry (NJRv7), the cemented stem referred to in the Figved et al 2009.**(7) paper,** the Spectron™ (Smith & Nephew, Inc, Memphis TN), is limited use in the UK. In fact, ranking 17th in the list of commonly implanted cemented devices, with only 130 implanted, the Spectron implant represented just 4% of all reported cemented implants in the UK in 2009. As NICE is making a recommendation on clinical practice in the UK; this is not a relevant comparator. It is also unclear if the cost of the cement and associated accessories has been considered in costing calculations used in Figved et al 2009.**(7)** This could represent a considerable addition the base cost of the implant (cement and cement accessories could amount to approximately 55% of the cost of a hip prosthesis*) and could skew the cost-	

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						effectiveness of cemented vs. uncemented implants. A more relevant cemented comparator would be the Exeter, (*Stryker, New Jersey, US*) which is, according the NJRv7, the most commonly implanted cemented hip in the UK. We would therefore direct NICE back to *the NHS supply catalogue for 2010 (stated as an existing reference in line 6, page 118)* for a comparative price. Alternatively, the Charnley hip implant, *(DePuy International Ltd., Warsaw, Indiana)* could be used as an appropriate comparator as it is the 2nd most commonly implanted hip in the UK. The additional savings associated with cementless technology such as a potential reduced length of stay could also impact cost effectiveness and should be fully investigated and incorporated into an unbiased comparison of the total procedural cost to the NHS. *(7) Figved W, Opland V et al.Cemented versus Uncemented Hemiarthroplasty for Displaced Femoral Neck Fractures. ClinOrthop Relat Res (2009) 467:2426-2435* **Cement and cement accessories required:* • *Cement* • *Cement Accessories:* ○ *Pulse lavage* ○ *Mixing set*	

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						○ *Extra sets of gloves* ○ *Femoral stem brush* ○ *Cement restrictor* ○ *Femoral pressuriser* ○ *Sterilization of trays*	
SH	DePuy International Ltd & Johnson & Johnson Medical	27.03	FULL	118	10	**10.4.3 Recommendation: Offer cementless implants to patients undergoing surgery with arthroplasty** Considering comments within the 'Trade off between clinical benefits and harms' section, within 10.4.3; 'Relative values of different outcomes' (page 118, line 10), this recommendation is based on an assumption that cemented stems cost less than cementless ones. However, the reduction in blood loss or the reduced duration of surgery shown in Figved et al 2009.**(7),** have not been considered. In Figved et al 2009 **(7),** which is used by NICE as a reference on page 118, line 3, in the uncemented group, the mean duration of surgery was 12.4 minutes shorter and the mean intraoperative blood loss was 89 mL less. The cost implications of this should be taken into consideration as they could have considerable impact on the overall cost-effectiveness of the uncemented implant. *(7) Cemented versus Uncemented*	Thank you for your comment. We have now added the following comment in the economic considerations in section 10.4.3: "The GDG does not consider the higher level of blood loss reported in Figved et al (2009) for patients receiving cemented implants (89mL) to be significant in terms of both patients' outcomes and costs. Furthermore, we have now added a further section in appendix H (section 20.8) where we have conducted a cost analysis on the cemented stems vs. uncemented stems (new design). Please refer to that section for further details.

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						Hemiarthroplasty for Displaced Femoral Neck Fractures. Figved W, Opland V et al. ClinOrthop Relat Res (2009) 467:2426-2435	
SH	DePuy International Ltd & Johnson & Johnson Medical	27.04	FULL	118	4	**10.4 Use of cement in arthroplasty** Quoted from draft guideline section 10.4 *"Thus a component fixed with cement may be more secure resulting in less pain after surgery and decreased need for surgical revision due to loosening of the prosthesis"* A component fixed with cement may be *initially* more secure resulting in less pain after surgery and decreased need for surgical revision due to loosening of the prosthesis. However it should also be recognised that the use of bone cement for fixation introduces a number of additional surgical complexities including bone bed preparation, effective cement pressurisation and avoidance of cement mantle defects that can lead to loosening of the prosthesis in the longer term. **(8), (9)** The 7th Annual NJR Report demonstrates that uncemented fixation has now overtaken cemented fixation in primary hip arthroplasty in England & Wales. However, it has been suggested that cementing may induce side effects including	Thank you for your comment. The studies identified found no evidence of safety issues with the use of cemented arthroplasties compared to uncemented. There is evidence that cemented arthroplasty leads to better mobility and less pain.

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						cardiac arrhythmias and cardiorespiratory collapse, both of which may be fatal. NPSA data reports 26 deaths and six cases of severe harm when bone cement was used during hip surgery between October 2003 and October 2008. Data from the MHRA reports 20 deaths and four cases of severe harm with bone cement between 2000 and 2008. The NPSA published advice on cementing techniques to reduce such risk. However, patients undergoing surgery for proximal femoral fractures are often elderly and frequently have multiple co morbidities, often severe. Therefore some intraoperative deaths may occur and be unrelated to the use of cement. *(8) Mulroy RD, Harris WH (1990) The effect of improved cementing techniques on component loosening in total hip replacement: an 11 year radiographic review. JBJS 72B:757–760* *(9) Star MJ, Colwell CW, Kelam GJ, Ballock RT, Walker RH (1994) Suboptimal (thin) distal cement mantle thickness as a contributory factor in total hip arthroplasty femoral component failure. J Arthroplasty 9(2):143–149*	

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SH	DePuy International Ltd & Johnson & Johnson Medical	27.05	FULL	127	1-6	**10.6.1.5 Recommendations and link to evidence** Considering comments in the trade off between clinical benefits and harms within 10.6.1.5. We agree that the analysis shows that there may be a higher incidence of operative or post-operative fracture with intramedullary nails. However, it does not provide evidence that there is a higher rate of re-operation with intramedullary nails. Therefore we do not believe that based on this analysis the conclusion that the higher fracture rate with the intramedullary nails causes a higher re-operation rate with intramedullary nails due to the higher fracture rate can be made. A further analysis of the reasons for re-operation with each device may be necessary to identify whether the re-operations for nails were due to facture and also to understand why the sliding hip screws were re-operated.	Thank you for your comment. We agree that the meta-analysis for reoperation (within follow up period of study) does not show any statistically significant difference between intramedullary nails and extramedullary devices (G-100 Appendix, and Table 10-53 full version, page 126). Our meta-analysis shows that there is also no difference in cut-out, infection, non-union or pain (Appendix G102-105) with either of these devices. This recommendation has been made because there is a statistically significant increase in operative or postoperative fracture with intramedullary nails compared to extramedullary and on the economic considerations listed on page 128: The price of intramedullary fixation devices varies but on average is three times the price of sliding hip screws for short nails and five times the price for long nails. As no significant benefit has been proven of the advantages of intramedullary devices over extramedullary devices, the GDG agreed to consider extramedullary implants cost-effective for hip fracture patients.
SH	DePuy International Ltd & Johnson & Johnson Medical	27.06	FULL	127	6	**10.6.1.5 Recommendations and link to evidence** Considering comments in the trade off between clinical benefits and harms within 10.6.1.5. Studies using original nail designs no longer implanted have been included in the meta-analysis. This may be a significant	Thank you for your comment. We agree and have included an additional meta-analysis in the appendix including only studies published after 2000. We have added a link to the new meta-analysis and have stated that by sub grouping the data, including only studies from 2000, there are no

Type	Stakeholder	Order No	Document	Page No	Line No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						confounding factor in the analysis. The older nails were Generally made from stainless steel and were a straight design. More recent IM hip nails are designed with a radius of curvature and angled to facilitate insertion and minimise the risk of damage to the anterior cortex of the femur. They are also produced from titanium rather than stainless steel enabling smaller diameters proximally and distally to more closely match the anatomy and reduce stiffness compared to stainless steel. These changes may reduce the risk of intra-operative and post operative complications such as fracture and it may be appropriate to conduct a subgroup analysis of studies that only include these designs if possible. It may also be appropriate to make reference to why contemporary nails may have a reduced risk of fracture compared with the older designs.	changes to the evidence statements. The linking evidence to recommendation has been updated to reflect this.
SH	College of Emergency Medicine	28.00	Full	12	30	The words 'For displaced intracapsular fracture:' relate not to 'key clinical area' f) but to g) and h) – simple formatting mistake	Thank you for your comment. We have amended the text to read: g) For displaced intracapsular fracture: • Internal fixation versus arthroplasty (hip replacement surgery) •Total hip replacement versus hemiarthroplasty (replacing the head of the femur only).'

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SH	College of Emergency Medicine	28.01	Full	General		The guideline makes no recommendation about the surgical management of undisplaced intracapsular fractures (only displaced intracapsular fractures are covered). This leaves an obvious gap in the guidance.	Thank you for your comment. This was not an area of focus included in the scope of the guideline. During the consultation when preparing the scope this was considered as low priority and uncontroversial. Surgeons should use their experience and judgement when deciding on how to fix these.
SH	College of Emergency Medicine	28.02	Full	35	5	The wording of recommendation 4.2.1 could be read to mean that MRI should be offered straight from the emergency department if hip fracture is suspected despite negative radiographs. This could lead to vast oversubscription of the service and be unworkable in practice. Suggestion: Further imaging (usually MRI) should be requested after a period of analgesia / observation - usually the next day – if continued suspicion (as already reflected in the introduction text to chapter 5).	Thank you for your comment. The document makes it clear that radiographs are always the first imaging method and it is only occult factures being considered here. These are comparatively rare, so that vast oversubscription is not anticipated. Furthermore, the earlier an accurate diagnosis is made the earlier an appropriate management plan can be made. Depending on resources and time of presentation it may therefore be advantageous to proceed to early MRI
SH	College of Emergency Medicine	28.03	Full	45	24	The described technique of obtaining three plain film radiographs routinely to exclude occult hip fracture is not referenced and seems to be at variance with standard practice in most imaging departments.	Thank you for your comment**.** We would again stress that the recommendation relates to the situation of continued clinical suspicion of occult hip fracture. Best use of plain images can avoid delay and the need for further scanning. The method is well established and is described in various reference papers and textbooks.

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SH	College of Emergency Medicine	28.04	Full	35	25	Recommendation 4.2.3 on analgesia seems to suggest that no pain assessment need to be made prior to giving analgesia in the emergency department (first actual assessment suggested to take place 30min after initial analgesia). Suggestion: Add 'immediately upon presenting at hospital' as an additional time point for pain assessment (i.e. between lines 25 and 26). Also, suggest move recommendation text of lines 23-24 to sit after line 28.	Thank you for your comment. We have added a bullet point and have changed the order of the recommendations as you suggested
SH	College of Emergency Medicine	28.10	Full	General		CEM has produced guidance on appropriate timescales for assessing, treating, and reassessing pain in patients with suspected hip fracture in emergency departments and the relevant document '2010 CEM Clinical Standards' should be referenced. http://www.collemergencymed.ac.uk/code/document.asp?ID=4688	Thank you for drawing our attention to the CEM document, which is clearly valuable. The recommendations comprise, however, a wide range of process targets for which we have not been in a position to derive the evidence. Further, while not in conflict, we have observed some small differences from our own guidance (for example in Standards 3 & 4). The GDG have not therefore felt it appropriate at this time to cross refer formally as part of the current Guideline, but have added a note under "other considerations".
SH	College of Emergency Medicine	28.11	Full	General		National audits have shown that emergency departments often struggle to obtain radiographs for patients with suspected hip fracture in an appropriate timeframe. The document quoted above contains guidance in this regard and should be referenced. http://www.collemergencymed.ac.uk/code/do	Thank you for your comment. Compliance with Emergency Department 4 hour targets falls outside the scope of this guideline.

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						Microsoft Word - NICE hip consult draf cument.asp?ID=4688	

These organisations were approached but did not respond:

3M Health Care Limited
Age Concern England
Age UK
Aintree University Hospitals NHS Foundation Trust
ArjoHuntleigh
Arthritis Care
Association of Anaesthetists of Great Britain & Ireland
Association of British Health-Care Industries
Association of British Insurers (ABI)
Association of Medical Microbiologists
Association of the British Pharmaceuticals Industry (ABPI)
Barnsley Hospital NHS Foundation Trust
Blackpool Teaching Hospitals NHS Foundation Trust
BMJ
Bolton PCT
Brighton and Sussex University Hospitals Trust
British National Formulary (BNF)
British Orthopaedic Association
British Pain Society
Cambridge University Hospitals NHS Foundation Trust (Addenbrookes)
Care Quality Commission (CQC)
Chartered Physiotherapists Promoting Continence (CPPC)
Commission for Social Care Inspection DO NOT USE - Replace by CQC

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Connecting for Health
ConvaTec
County Durham PCT
Daiichi Sankyo UK
Department for Communities and Local Government
Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI)
Department of Health, Social Services & Public Safety, Northern Ireland (DHSSPSNI)
Devon PCT
Eli Lilly and Company Ltd
English Community Care Association
GE Healthcare
Harrogate and District NHS Foundation Trust
Health Advisory Forum
Heart of England NHS Foundation Trust
Imperial College Healthcare NHS Trust
Leeds PCT
Leeds Teaching Hospitals NHS Trust
Liverpool Community Health
Liverpool PCT Provider Services
Lothian University Hospitals Trust
Luton & Dunstable Hospital NHS Foundation Trust
Medicines and Healthcare Products Regulatory Agency (MHRA)
Merck Sharp & Dohme Ltd
Ministry of Defence (MoD)
National Patient Safety Agency (NPSA)
National Public Health Service for Wales
National Treatment Agency for Substance Misuse
Network of Orthogeriatricians in Wales (NOW)
NHS Clinical Knowledge Summaries Service (SCHIN)
NHS Derbyshire County
NHS Kirklees
NHS Plus
NHS Quality Improvement Scotland
NHS Sefton
NHS Sheffield
NHS Western Cheshire
North Cumbria Acute Hospitals NHS Trust
Nottinghamshire County Teaching PCT
Novartis Pharmaceuticals UK Ltd

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Nutricia Ltd (UK)
Nutricia Ltd (UK)
Patients Council
PERIGON Healthcare Ltd
Pfizer Limited
Philips Healthcare
Poole and Bournemouth PCT
Princess Alexandra Hospital NHS Trust
Procter and Gamble Pharmaceuticals
QResearch
Relatives & Residents Association
Robinson Healthcare Ltd
Rotherham NHS Foundation Trust
Rotherham NHS Foundation Trust
Royal College of Anaesthetists
Royal College of General Practitioners Wales
Royal College of Midwives
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Physicians London
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Surgeons of England
Royal Liverpool and Broadgreen University Hospitals NHS Trust
Sandwell PCT
Sanofi-Aventis
Scottish Intercollegiate Guidelines Network (SIGN)
Sheffield PCT
Sheffield Teaching Hospitals NHS Foundation Trust
Shropshire County PCT
Social Care Institute for Excellence (SCIE)
Social Exclusion Task Force
Solent Healthcare
South East Coast Ambulance Service
South East Wales Critical Care Network
South Staffordshire PCT
Spinal Injuries Association
St Helens Hospital

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Surgical Dressing Manufacturers Association (SDMA)
Synthes Ltd
Tenscare Ltd
Tower Hamlets PCT
United Kingdom Clinical Pharmacy Association (UKCPA)
University College London Hospitals (UCLH) Acute Trust
University Hospitals Bristol NHS Foundation Trust
University of Sheffield
Welsh Assembly Government
Welsh Scientific Advisory Committee (WSAC)
West Hertfordshire Hospital Trust
Western Cheshire Primary Care Trust
Western Health and Social Care Trust
Win Health Ltd
Worcestershire PCT
York Teaching Hospital NHS Foundation Trust