Hip fracture: management (update)

Consultation on draft guideline - Stakeholder comments table
06 October 2022 – 20 October 2022

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British Orthopaedic Association	Guideline	General	General	Finally, we understand that this was a review of a limited part of the guidance, but we remain disappointed that NICE did not undertake a more wide-ranging revision of this guidance, recognising the multi-disciplinary nature of hip fracture care and the comparatively small role that technical aspects of surgery play in the long-term outcomes for people with hip and other lower limb fragility fractures.	Thank you for your comment. This partial update focused specifically on surgical procedures based on a surveillance review and an exceptional surveillance review that identified new evidence in this area. The surveillance review did not identify new evidence in other areas of the guideline that would have an impact on existing recommendations, therefore these were not chosen for update. Details of the surveillance review can be found here: https://www.nice.org.uk/guidance/cg124/resources/2019-surveillance-of-hip-fracture-management-nice-guideline-cg124-6963979504/chapter/Surveillance-decision?tab=evidence
British Orthopaedic Association	Guideline	004	008	1.6.3 - In light of an increasing body of evidence, we welcome the additional flexibility for surgeons to offer hemiarthroplasty instead of total hip replacement to patients in wider circumstances. We also welcome the acknowledgment that risks may be associated with cognitive function as well as physical function. However, we are concerned that the current wording is vague and difficult to measure, with the subsequent risk that units will be unable to audit and benchmark against a national standard. We ask the authors to consider re-wording this recommendation, particularly the phrases "makes the procedure unsuitable for them" and "carry out activities of daily living independently in the long-term"	Thank you for your comments in support of the recommendation. The committee feel that there are a range of comorbidities and resulting levels of functionality which need to be considered before choosing THA over HA, and it is important that this decision is made in the context of a multidisciplinary team with a range of expertise to assess this. We have added additional information about the importance of multidisciplinary teams being part of this decision making in the guideline rationale and the evidence review. No evidence was found relating to different subpopulations to enable the committee to make more specific recommendations, and there was only limited evidence for people with cognitive impairment. Having reviewed the wording, and considering the limited evidence base, the committee decided to remove the

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					reference to cognitive impairment with the emphasis of the recommendation placed on functionality. The new criteria will give multidisciplinary teams the ability to make more patient focused decisions and also represents the three stages of a patient's situation, i.e.1) their functional ability prior to fracture, 2) how they present on the day and their suitability for the operation, 3) their functional ability in the future. We have amended the third bullet point so that clinicians consider the functional benefits patients can get beyond 2 years, as the health economic model shows THA as cost-effective beyond this time point. In relation to the audit, it is the committee's understanding that there is large variation in practice in relation to the existing recommendation with low compliance. The committee think it is possible for the audit to be adapted by the NHFD to match the updates to the recommendation. By recording how many people have received THA or HA and looking at where and why there are differences in practice, the committee think it is possible to audit the compliance to this recommendation.
British Orthopaedic Association	Guideline	005	008 + 011	1.6.5 & 1.6.6 - We agree that these are pragmatic recommendations that support use of implants that are familiar to the whole surgical team.	Thank you for your comment.
British Orthopaedic Association	Guideline	005	014	1.6.7 - We support the wider use of registries to collate data on clinical outcomes of hemiarthroplasties.	Thank you for your comment.

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British Orthopaedic Association	Guideline	006	001	1.6.9 - We appreciate that this recommendation is not specifically part of the current review. However, we note that, since the guidance was written, amendments have been made to the AO classification on the basis of limited evidence and which make the classification less clear. The new description of A2 fractures may be interpreted differently, which would encourage the use of an intramedullary device rather than a sliding hip screw. Our suggestion is that the bracketed phrase "AO classification types A1 and A2" could be removed from this recommendation without a material effect on the meaning of the recommendation, which is that trochanteric fractures should be managed with a sliding hip screw.	Thank you for your comment. Although this is out of scope, we have checked this with our committee who agree with your suggestion to remove AO classification types A1 and A2 as the classification has been modified since the guideline published. The committee have also agreed to add 'except reverse oblique' in its place, as recognising the direction of the fracture line will further help clinicians when exercising judgement about on the method of treatment.
National Joint Registry	Guideline	009	015	We wanted to draw attention to the fact that the NJR will start collecting data on hip hemiarthoplasty procedures from April 2023. You may wish to draw attention to this in the published guideline.	Thank you for your comment. We are pleased to hear the NJR will be collecting data on hip hemiarthroplasty which will align with the updated recommendation.
National Joint Registry	Guideline	010	003	We wanted to draw attention to the fact that the NJR will start collecting data on hip hemiarthoplasty procedures from April 2023. You may wish to draw attention to this in the published guideline.	Thank you for your comment. We are pleased to hear the NJR will be collecting data on hip hemiarthroplasty which will align with the updated recommendation.
NHS England	General	General	General	• It has been recommended that the BAME and LGBTQ+ communities to be included in the stakeholders list, as their needs might require specific assessment and management approach. • It is helpful to have sighted the original Equality Impact Assessment during the scooping exercise as well as the final version. It is good to see the GDG recognised, that a high proportion of this group of patients is	Thank you for your comment. It appears your comment relates to the EIA and stakeholder list from the full guideline and not this partial update focusing specifically on surgical procedures. The final scope of this update can be found here https://www.nice.org.uk/guidance/gid-ng10280/documents/final-scope-2 In relation to our stakeholder list, we encourage a wide representation from stakeholder groups, including

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				elderly and frail and cognitive impairment is common. However, it is also important to acknowledge individuals from other protected groups such as the marginalised communities and the BAME communities might require specific attention as their accessibility might complicate their assessment and management approach. We have also noted there are some AHP professional bodies who are in the stakeholders list (but not exhaustive). Due to the nature of the AHPs' work, it is recommended that all professional bodies should be included in similar context in the future.	those representing BAME and LGBTQ+ communities and it is the decision of those groups to choose to register as stakeholders. We also welcome the NHS alerting key AHP bodies to register as stakeholders.
NHS England	General	General	General	Agree with the recommendations of replacement in those who were functionally well and able to walk unaided and carry out ADL pre op with early rehab to encourage early mobility.	Thank you for your comment
NHS England	General	General	General	Other co-morbidities, including medications (DOAC/warfarin/antiplatelets) and cognition need to be considered and this has been referenced in the document.	Thank you for your comment
NHS England	Guideline	005	1.1	Imaging in occult hip fracture-might be worth a few lines about how to manage for GPs (or a link to this guidance). GPs often called to patients who have fallen with hip pain but no overt signs (ie shortening and external rotation) and may, to avoid harm, try and manage in community rather than transfer to ED, especially if elderly/frail and already in nursing home. GPs need some guidance for what to do if ongoing symptoms and normal Xray.	Thank you for your comment. It appears your comment relates to a section of the full guideline which is not being updated at this time and is therefore out of scope. This was a partial update focusing specifically on surgical procedures. The final scope of this update can be found here: https://www.nice.org.uk/guidance/gid-ng10280/documents/final-scope-2
NHS England	Guideline	014	005	Early supported discharge-morally the right thing to do but will have an impact on primary care workload so	Thank you for your comment. It appears your comment relates to a section of the full guideline which is not

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				needs stakeholder buy in. Also really important that ESD does come with the resources **already in place** i.e. Physio etc and not to expect the GP to organise this	being updated at this time and is therefore out of scope. This was a partial update focusing specifically on surgical procedures. The final scope of this update can be found here https://www.nice.org.uk/guidance/gid-ng10280/documents/final-scope-2
Royal College of Physicians (RCP)	General	General	General	The RCP is grateful for the opportunity to respond to the above consultation. We have liaised with our Falls and Fragility Fracture Audit Programme (FFFAP) and would like to comment as follows.	Thank you for your comment
Royal College of Physicians (RCP)	Guideline	General	General	Our experts are pleased to see the update to the NICE surgical recommendations for hip fracture, particularly since many participants in the National Hip Fracture Database (NHFD) have asked whether the HEALTH study will lead to change in how we audit the provision of total hip replacement in patients with hip fracture.	Thank you for your comment.
Royal College of Physicians (RCP)	Guideline	General	General	Our experts are disappointed at the draft wording of the guideline. It is less clear than the previous version and more open to misinterpretation.	Thank you for your comment. It is the committee's understanding that there is large variation in practice in relation to the existing recommendation with low compliance in offering THA where the criteria previously stated it should be offered. Changing this recommendation from 'offer' to 'consider' THA along with adding the bulleted criteria will give clinicians and multidisciplinary teams more discretion to justify not giving THA where they think this would be inappropriate. For most outcomes, the evidence was unable to differentiate between the two treatments and therefore they were unable to be more specific about the criteria. We have amended the third bullet point so that clinicians consider the functional benefits patients can get beyond 2 years, as the health economic

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					model shows THA as cost-effective beyond this time point. The committee feel that there are a range of comorbidities and resulting levels of functionality which need to be considered before choosing THA over HA, and it is important that this decision is made in the context of a multidisciplinary team with a range of expertise to assess this. No evidence was found relating to different subpopulations to make more specific recommendations; however, the committee did include a research recommendation that specified the importance of looking at different subpopulations. This is intended to provide more information about who will benefit most from THA or HA, and enable more detailed recommendations to be made in future.
Royal College of Physicians (RCP)	Guideline	General	General	Our experts believe that the guideline's acceptance of surgeon preference means the NHFD will no longer be able to directly audit individual units' compliance with NICE Guidance. The NHFD's key performance indicator *KPI3: NICE Compliance* was built upon the more objective structure of the 2011 and 2016 guidance, and looking at performance figures in 2021 https://www.nhfd.co.uk/20/NHFDCharts.nsf/vwcharts/KPI3-NICEcompliance?open there is still enormous variation between hospitals.	In relation to the audit, it is the committee's understanding that there is large variation in practice in relation to the existing recommendation with low compliance. The committee think it is possible for the audit to be adapted by the NHFD to match the updates to the recommendation. By recording how many people have received THA or HA and looking at where and why there are differences in practice, the committee think it is possible to audit the compliance to this recommendation. While the committee agree with the importance of auditing by the NHFD, they do not think that giving clinicians greater discretion in making decisions about a patient's care is a negative thing in relation to this treatment decision.

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Royal College of Physicians (RCP)	Guideline	General	General	The NHFD's role is to challenge discrepancies between hospitals and to provide the information they need to understand the approach taken by their surgeons https://www.nhfd.co.uk/20/NHFDCharts.nsf/vwcharts/Surgery?open. This guideline may prevent the NHFD from doing this. The proposed wording has the potential to allow surgeons a free hand to pursue their own judgement, prejudice, or convenience.	While the committee agree with the importance of auditing by the NHFD, they do not think that giving clinicians greater discretion in making decisions about a patient's care is a negative thing in relation to this treatment decision. In relation to the audit, it is the committee's understanding that there is large variation in practice in relation to the existing recommendation with low compliance. The committee think it is possible for the audit to be adapted by the NHFD to match the updates to the recommendation. By recording how many people have received THA or HA and looking at where and why there are differences in practice, the committee think it is possible to audit the compliance to this recommendation.
Royal College of Physicians (RCP)	Guideline	004	008	**1.6.3 Consider total hip replacement rather than hemiarthroplasty for patients with a displaced intracapsular hip fracture who:** • **were able to walk independently out of doors with no more than the use of a stick and** • **do not have a condition or comorbidity that makes the procedure unsuitable for them (including cognitive impairments that put them at increased risk of dislocations) and** • **are expected to be able to carry out activities of daily living independently in the long term. [2022]**	Thank you for your comment. It is the committee's understanding that there is already large variation in practice in relation to the existing recommendation with low compliance in offering THA where the criteria previously stated it should be offered. Changing this recommendation from 'offer' to 'consider' THA along with adding the bulleted criteria will give clinicians and multidisciplinary teams more discretion to justify not giving THA where they think this would be inappropriate. For the majority of outcomes, the evidence was unable to differentiate between the two treatments and therefore they were unable to be more specific about the criteria. We have amended the third bullet point so that clinicians consider the functional benefits patients can get beyond 2 years, as the

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				Our experts question the proposed wording for Recommendation 1.6.3. Previous NICE guidance provided a clear framework that clinicians might use to justify a decision to only offer hemiarthroplasty, recognising that this might be inappropriate in people with significant mobility problems, or medical comorbidity or dementia.	health economic model shows THA as cost-effective beyond this time point. The committee feel that there are a range of comorbidities and resulting levels of functionality which need to be considered before choosing THA over HA, and it is important that this decision is made in the context of a multidisciplinary team with a range of expertise to assess this. No evidence was found relating to different subpopulations to make more specific recommendations; however, the committee did include a research recommendation that specified the importance of looking at different subpopulations. This is intended to provide more information about who will benefit most from THA or HA, and enable more detailed recommendations to be made in future.
Royal College of Physicians (RCP)	Guideline	004	008	We would suggest that Recommendation 1.6.3 would be more impactful, and more amenable to monitoring in local and national audits if the second bullet point is omitted; the first and third bullet points already cover the patients to which it refers.	Thank you for your comment. The committee thought that the second bullet point is useful for clinicians. Having reviewed the wording however, and considering the limited evidence base, the committee decided to remove the reference to cognitive impairment with the emphasis of the recommendation placed on functionality The committee agree that cognitive impairment will have different levels of severity depending on the person and it is one of many comorbidities which need to be considered when making treatment decisions. The three bullet points represent three stages of a patient's pathway, i.e.1) their functional ability prior to fracture, 2) how they present on the day and their suitability for the operation, 3) their future functionality. We have also amended the third bullet point so that clinicians

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					consider the functional benefits patients can get beyond 2 years, as the health economic model shows THA as cost-effective beyond this time point. The committee think it is possible for the NHFD to adapt their requirements for the audit to match the updates to the recommendation. By recording how many people have received THA or HA and looking at where and why there are differences in practice, the committee think it is possible to audit the compliance to this recommendation.
Royal College of Physicians (RCP)	Guideline	004	012	Recommendation 1.6.3 - Our experts believe that the wording proposed in the 2022 draft appears less focused. The second bullet 'exclusion' criterion '*do not have a condition or comorbidity that makes the procedure unsuitable for them'* is vague and could be applied to any patient. It is also unnecessary as no surgeon would perform an 'unsuitable' procedure.	Thank you for your comment. The committee thought that the second bullet point is useful for clinicians. The three bullet points represent three stages of a patient's pathway, i.e.,1) their functional ability prior to fracture, 2) how they present on the day and their suitability for the operation, 3) their future functionality.
Royal College of Physicians (RCP)	Guideline	004	013	Recommendation 1.6.3 - Our experts believe that the second bullet is further complicated by the additional phrase '*including cognitive impairments that put them at increased risk of dislocations'.* Our experts accept that patients with significant dementia and delirium may not be able to follow 'hip precautions'. However, people presenting with hip fracture are assessed for cognitive impairment using the Abbreviated Mental Test (AMT) and we are not aware of evidence linking any specific AMT threshold with increased risk of dislocation. If the literature review has identified one this could be cited, but otherwise there is a risk that this advice is applied to patients with any degree of cognitive impairment.	Thank you for your comment. The committee agree that cognitive impairment will have different levels of severity and it was the intention of the wording to highlight that it was only cognitive impairment severe enough to result in future dislocations that should act as exclusion criteria. Having reviewed the wording, and considering the limited evidence base for this, the committee have decided to remove the reference to cognitive impairment with the emphasis of the recommendation placed on functionality prior to fracture and in the future.

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Royal College of Physicians (RCP)	Guideline	004	015	Recommendation 1.6.3 - Our experts believe that any patient with cognitive impairment sufficient to prejudice their ability to follow 'hip precautions' (ie. dementia) should in any case be excluded based on the third bullet point '*are expected to be able to carry out activities of daily living independently in the long term'.*	Thank you for your comment. The committee agree that cognitive impairment will have different levels of severity and it was the intention of the wording to highlight that it was only cognitive impairment severe enough to result in future dislocations that should act as exclusion criteria. Having reviewed the wording, and considering the limited evidence base for this, the committee have decided to remove the reference to cognitive impairment with the emphasis of the recommendation placed on functionality prior to fracture and in the future.
The British Geriatrics Society	Guideline	General	General	We welcome and support the proposed update to the 2016 guidance. We're aware that in terms of surgical procedures the evidence has improved recently, though there is little change that would be immediately of concern to BGS members and their patients.	Thank you for your comment
The British Geriatrics Society	Guideline	004	008	We appreciate the intention behind Recommendation 1.6.3 but would ask that the wording might be reconsidered. Previous NICE guidance provided a simple list of three reasons that might justify surgeons not offering a THR to people with limited mobility, serious medical/anaesthetic concerns or dementia. This structure provides the basis for NICE guidance to be audited by the National Hip Fracture Database (NHFD). Changing the wording will limit the NHFD's ability to challenge variation in surgical practice through its Key Performance Indicator 3 which specifically measures compliance with the 2016 recommendation.	Thank you for your comment. While the committee agree with the importance of auditing by the NHFD, they do not think that giving clinicians greater discretion in making decisions about a patient's care is a negative thing in relation to this treatment decision. The committee feel that there are a range of comorbidities and resulting levels of functionality which need to be considered before choosing THA over HA, and it is important that this decision is made in the context of a multidisciplinary team with a range of expertise to assess this. We have added additional information about the importance of multidisciplinary teams being part of this decision making in the guideline rationale and the evidence review. We have also amended the third bullet point so that clinicians consider the functional benefits patients can get

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				The proposed wording of recommendation 1.6.3 would not be auditable as it includes exclusion criteria that are poorly defined. These would not be measurable by the NHFD as there is no way for the national clinical audit or local audit work) to record or categorise subjective surgeon opinions such as "do not have a condition or comorbidity that makes the procedure unsuitable for them". This subjectivity is compounded by inclusion of cognitive impairment as one justification for such a surgical decision. Patients with cognitive impairment that means they are unable to understand hip precautions will be those who have dementia. These people have a poor long-term prognosis and as a result should not be offered THR on the basis of the third bullet point. Orthopaedic surgeons' will not be able to assess the functional consequences of more subtle levels of cognitive impairment, and geriatricians would be concerned that some surgeons may elect to refuse a THR to any patient with a less than perfect Abbreviated Mental test score (the only cognitive assessment available on the decision making post-take orthopaedic round), even though some of these patients will only be scoring poorly because they are drowsy or temporarily delirious in the face of acute pain and/or analgesia.	beyond 2 years, as the health economic model shows THA as cost-effective beyond this time point. No evidence was found relating to different subpopulations to enable the committee to make more specific recommendations, and there was only limited evidence for people with cognitive impairment. The committee agree that cognitive impairment will have different levels of severity and it was the intention of the wording to highlight that it was only cognitive impairment severe enough to result in future dislocations that should act as exclusion criteria. Having reviewed the wording, and considering the limited evidence base, the committee have decided to remove the reference to cognitive impairment with the emphasis of the recommendation placed on functionality. The new criteria will give multidisciplinary teams the ability to make more patient focused decisions and also represents the three stages of a patient's situation, i.e.1) their functional ability prior to fracture, 2) how they present on the day and their suitability for the operation, 3) their functional ability beyond 2 years. In relation to the audit, it is the committee's understanding that there is large variation in practice in relation to the existing recommendation with low compliance. The committee think it is possible for the audit to be adapted by the NHFD to match the updates to the recommendation. By recording how many people have received THA or HA and looking at where

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				These concerns could be avoided by missing out the second bullet point, which we feel adds nothing to the recommendation and will prevent its being auditable by the NHFD. However the third bullet point is also a concern. It is not currently possible to reliably predict a patients future long-term function, but any attempt at prediction should be based on an understanding of their pre-fracture function. This should be based on knowledge of objective factors, and specifically their mobility, residence, and medical/psychiatric comorbidity, which is precisely the approach taken in the 2011 and 2016 guidance. For all these reasons we would recommend that the previous 2016 recommendation be reinstated.	and why there are differences in practice, the committee think it is possible to audit the compliance to this recommendation.
The Royal College of Surgeons of Edinburgh	Guideline	General	General	Thank you for enabling us at the Surgical Speciality Board of the RCSEd to afford comment on the proposed changes to the guideline touching on the care of patients admitted with a fracture of the proximal femur. We appreciate that the main issue at play here is the uptake and appropriate use of total hip replacement (THR) in this population. We equally understand the import of the recent release of studies pertaining to performance of differing modes of arthroplasty in the management of intracapsular hip fracture. Access for all to appropriate care is vital to patients looked after by our members. We understand that enabling patients, regardless of cognitive status,	Thank you for your comment. Only limited evidence for people with cognitive impairment was found. The committee note that cognitive impairment will have different levels of severity and it was the intention of the wording to highlight that it was only cognitive impairment severe enough to result in future dislocations that should act as exclusion criteria. Having reviewed the wording, and considering the limited evidence base, the committee have decided to remove the reference to cognitive impairment with the emphasis of the recommendation placed on functionality.

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				access to optimum care is central to trauma and orthopaedics. At the RCSEd however we would like to express concern regarding the perspective in which this concern or enablement of access is placed with regards THR. The literature supporting the use of THR in the management of the generality of intracapsular hip fracture is increasingly challenged and by contrast most significant, well-constructed works of the last few years have demonstrated no gain when compared to hemiarthroplasty. Poor cognitive function can be (but not always is) a risk factor for dislocation of a THR and as such we feel that in the absence of benefit and with the potential for harm, the wording proposed is confusing, unauditable and will not improve access to care. We fully appreciate the drive to ensure that cognitively impaired patients are not disadvantaged or lack access to optimum care. With this management choice however, there is no disparity in access when risk benefit is considered. Misinterpretation of guidelines may however actually put patients at risk. Worded as it is, auditing bodies such as the NHFD will not be able to assess the impact of change and as such, awareness of impact and harm may go unnoticed. It is simply fixed with attention to the second bullet point and members of the board would be happy to contribute should the need arise.	The new criteria will give multidisciplinary teams the ability to make more patient focused decisions and also represents the three stages of a patient's situation, i.e.1) their functional ability prior to fracture, 2) how they present on the day and their suitability for the operation, 3) their future functionality at 2 years and beyond. In relation to the audit, it is the committee's understanding that there is large variation in practice in relation to the existing recommendation with low compliance. The committee think it is possible for the audit to be adapted by the NHFD to match the updates to the recommendation. By recording how many people have received THA or HA and looking at where and why there are differences in practice, the committee think it is possible to audit the compliance to this recommendation.

**None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.*