National Hip Fracture Database user guide 2016

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NHFD data collection webtool and www.nhfd.co.uk are provided by Crown Informatics
www.crowninformatics.com

Falls and Fragility Fracture Audit Programme (FFAP)
The National Hip Fracture database (NHFD) is commissioned by the Healthcare Quality improvement Partnership (HQIP) and managed by the Royal College of Physicians (RCP) as part of the Falls and Fragility Fracture Audit Programme (FFAP) alongside the Fracture Liaison Service Database (FLS-DB) and Falls Pathway workstream. FFFAP aims to improve the delivery of care for patients having falls or sustaining fractures through effective measurement against standards and feedback to providers.

Healthcare Quality improvement Partnership (HQIP)
The Healthcare Quality Improvement Partnership (HQIP) is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. Its aim is to promote quality improvement, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales. HQIP hosts the contract to manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP). Their purpose is to engage clinicians across England and Wales in systematic evaluation of their clinical practice against standards and to support and encourage improvement in the quality of treatment and care. The programme comprises more than 30 clinical audits that cover care provided to people with a wide range of medical, surgical and mental health conditions.

The Royal College of Physicians (RCP)
The Royal College of Physicians is a registered charity that aims to ensure high quality care for patients by promoting the highest standards of medical practice. It provides and sets standards in clinical practice and education and training, conducts assessments and examinations, quality assures external audit programmes, supports doctors in their practice of medicine, and advises the government, public and the profession on healthcare issues.

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Contact us

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Introduction

This document has been produced by Crown Informatics and the National Hip Fracture Database (NHFD) team as a resource for current and new users of the NHFD website. All headings in the contents page are linked to the appropriate chapter for ease of navigation. However, it is advised that both experienced and new users take the time to read through the whole document to provide a better understanding of the process of data submission, to improve the quality of the data submitted and become familiar with the tools and documents available on the website to help improve hip fracture services.

Accessing the NHFD

Lead clinicians

The NHFD lead clinician at each participating hospital is responsible for:

- checking the quality of the data submitted to the NHFD from their site
- authorising access to new users and ensuring only the appropriate people have access to the data, and that each has the correct level of access
- data governance
- being the first point of contact for the NHFD.

The lead clinician must be a consultant anaesthetist, (ortho)geriatrician, orthopaedic surgeon or physician. They are not necessarily the service lead for trauma within the Trust, but a consultant with a particular interest in ensuring that patients with hip fractures receive the best practice standard of care.

Each hospital must have a lead clinician, and two clinicians may share the role. A person may be the lead clinician for more than one site.

Data checking

We recommend that lead clinicians check a random sample of data (15% of records) each month to ensure data accuracy.

Leads should also make monthly checks of their hospital’s exceptions report, to verify or correct any records that are highlighted as containing unlikely data. The exceptions report is available in the ‘Reports’ tab.
Levels of access

There are currently three levels of access to the NHFD website:

- **Public access** – This allows access to news, published reports and the resources section of the website. A username and password is not needed to access these areas.

- **Read only access** – This allows the user to view all records entered to the NHFD, as well as the reports and run charts, but it does not allow the user to enter, amend or export data. Password and username required. This level of access is recommended for staff that need to review reports. Lead clinicians can export the data in spreadsheet form if required.

- **Full access** – A password is needed for this level of access and it allows users to create new records, update and edit patient data and export data in spreadsheet format. Users can also view reports and run charts.

Getting access to the database

The lead clinician at each site is responsible for authorising access to their hospital’s data.

Any registered user can create a new user account for a colleague:

- log in to the NHFD
- select ‘Request Access/Account Manager’, then ‘Register a user’
- enter the new user’s details and submit.

This request will then automatically be sent to the lead clinician, who will need to log in and approve or decline it. If the lead clinician creates the new user account it will be automatically authorised at that time.
Logging into the database

- Go to [www.nhfd.co.uk](http://www.nhfd.co.uk) and click ‘Login’ in the top right corner
- Enter your username and password on the Crown Audit page that appears and click ‘Sign In’
- Select ‘National Hip Fracture Database’ in the purple ‘Your Applications’ box
- Read the warning in the box that appears and click ‘I agree’.

From the FFFAP website ([www.fffap.org](http://www.fffap.org))

- Click the orange ‘Sign In’ box in the top right corner to log in as above.
- Select ‘Visit the Site’ in the teal NHFD box on the left to navigate to the NHFD website. From there you can also log in as above.
Forgotten password or user name

To reset forgotten login details, click on ‘Forgot username?’ or ‘Forgot password?’ in the login page, or click the green ‘Support’ button. Then choose from ‘Reset password’ or ‘Username reminder’.
Always log out of the database by clicking on the cross next to your username at the end of the session.
Entering data

Viewing existing records

Click on the ‘Patient Data’ tab to view your site’s records.

On the menu on the left you can create new records and update existing records.

**Active patients**: these are patients for whom some details have been entered. Records cease to be active upon completion of a valid discharge from trust date.

**Draft records**: these are records where one or more of the mandatory fields is incomplete.

Creating a new patient record

All patients admitted from 1 January 2016 should be entered into the NHFD database using the current v9 dataset. (v8 option will remain open until the end of 2016 to allow the entry of 120-day follow-up data.)

Once you have logged in, select the ‘Patient Data’ tab and click on ‘New Patient (V9)’. This will open a blank record for you to complete. Click through the tabs to enter the data in each section.

You will only be able to save the record once the patient ID/hospital number and side of fracture have been entered, as these are needed to create the Artemis number, the unique code which identifies each record.
You can update/amend a record as many times as necessary, just ensure you click ‘Save’ before exiting each time. The record will remain in draft until all of the mandatory fields have been completed (these are marked with an M on the paper audit tool):

- NHS / CHI number
- Date of birth
- Sex
- Patient’s post code
- Residence before this hospital admission
- Date & time of admission to A & E
- Admission Date/time to orthopaedic/orthogeriatric ward
- Orthopaedic GMC number (Name)
- Geriatrician GMC number (Name)
- Type of fracture
- Pathological
- Operation performed
- Reason if delay > 36 hours
- Pressure ulcers
- Date & time assessed by geriatrician
- Geriatrician grade
- Specialist falls assessment
- Multidisciplinary rehabilitation team assessment
- Bone protection medication
- Date of discharge from acute orthopaedic ward
- Discharge destination from acute orthopaedic ward
- Date of final discharge from Trust
- Discharge destination from Trust

**Important points to remember when entering data:**

- Always use the calendar icon for data entry when date and time are required. Type in the correct time hh:mm, and then select the correct day and month

```
Date of Birth (dd/mm/yyyy)
```

- Use the 'help' buttons to aid understanding of what is required in a particular field

```
NHS / CHI Number
```

- Pop-up boxes may appear if invalid or unlikely data are entered. If a record is incomplete when you click ‘Save’, a pop-up box with a list of incomplete mandatory fields will appear. The record will remain in draft until these fields have been completed.
Which patients should go on the database?

All patients aged 60 and over with a hip fracture (ie those that would be coded as S72.0, S72.1, S72.2 in ICD10), including subtrochanteric fractures, should be submitted to the NHFD. This is regardless of the mechanism of the fracture.

Data on every patient admitted to your hospital with a hip fracture should be submitted to NHFD. However, NHFD only collects the primary fracture for each hip, so please do not enter patients who have had a previous admission for a hip fracture on the same side.

The hospital carrying out the definitive treatment (surgery or decision to treat conservatively) should enter the patient in the database.

The scenarios below are provided to assist with correct data entry:

1. **The patient attends A&E, but is transferred to another hospital for treatment**: the hospital giving the patient their definitive treatment creates the record, but it will state that the first presenting hospital is where the A&E admission occurred, and record the time of admission to that A&E department.

2. **No surgical intervention on primary admission**: the patient is discharged but returns at a later date complaining of pain and inability to mobilise. The patient is readmitted and undergoes surgery. NHFD only collects data on the primary fracture episode so the second admission should **NOT** be entered onto the database. This patient will not qualify for Best Practice Tariff (BPT) as surgery has not been performed during the primary episode.
3. The patient has surgery but then needs to have a second operation relating to their hip fracture within 120 days of admission: this should be recorded by editing the original record and selecting the appropriate response in the ‘reoperation’ field found in the ‘Follow-up’ tab.

4. The patient has surgery but then needs to have a second operation relating to their hip fracture more than 120 days after admission: NHFD does not collect this data.

**What information do I need to submit?**

The data required for each patient (dataset) is specified on a data collection sheet that should generally be printed out and completed during the admission in order to achieve the highest level of data completeness and accuracy. The data can then be transferred to the webtool. The data is entered in the series of tabs.

Fields marked ‘M’ on the data collection sheet are mandatory and the record will remain in draft until all these fields are completed. Fields marker ‘K’ are key fields and the system will not create a record until these fields are completed.

**Dataset review**

The NHFD dataset is reviewed annually to ensure that only data pertinent to patient care at each hospital are collected. Each of the fields in the dataset is important to help hospitals evaluate the service they provide, discover any shortfalls and monitor improvements in care. Most fields have help buttons beside them to provide further information. This guide and the help buttons are designed to enable the submission of high quality data.
# Explanation of the dataset fields

Calendar icons should be used to complete all date and time fields.

## Patient information fields

<table>
<thead>
<tr>
<th>Field</th>
<th>Format</th>
<th>Validation</th>
<th>Status</th>
<th>Why required</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>First name</td>
<td>Free text</td>
<td>Validation in place to ensure only one name entered.</td>
<td>Optional</td>
<td>Collected as a secondary identifier for data matching. Use for local use for follow-up.</td>
<td>Enter normal first name or given name. First name only, no middle names or initials.</td>
</tr>
<tr>
<td>Surname</td>
<td>Free text</td>
<td>Validation in place</td>
<td>Optional</td>
<td>Collected as a secondary identifier for data matching. Use for local use for follow-up.</td>
<td>Surname only- no suffixes/honours etc.</td>
</tr>
<tr>
<td>NHS number/ CHI number</td>
<td>Numbers (10 digits).</td>
<td>Digit validation in place to ensure valid NHS number</td>
<td>Mandatory, also used for BPT.</td>
<td>NHS number is essential to ensure that each patient is uniquely identified and for patient matching to third party data sources for mortality, superspell and BPT (in England) and therefore must be completed whenever possible.</td>
<td>If a patient residing in the UK does not have an NHS number please contact your medical records department for advice. If the patient is not a resident in the UK please insert ‘NA’ in this field.</td>
</tr>
<tr>
<td>Date of birth</td>
<td>dd/mm/yyyy</td>
<td>Validation in place- only patients aged 60 and</td>
<td>Mandatory, also used for</td>
<td>Date of birth is used as a secondary identifier for data</td>
<td>Ages under 60 will generate an error. Ages</td>
</tr>
</tbody>
</table>
### Over accepted BPT matching.

Age at event is used to analyse casemix. Up to 120 accepted, but ages over 110 will generate a warning to check age.

<table>
<thead>
<tr>
<th>Field</th>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Select one option</td>
<td>One option required Mandatory Sex is used to analyse casemix.</td>
</tr>
<tr>
<td>Patient’s post code</td>
<td>Alphanumeric</td>
<td>Value will be checked against legal post code formats and converted to upper case. See this field’s help button for details of post code formatting restrictions. Mandatory Collected as a secondary identifier for data matching. Allows calculation of deprivation scoring. If you do not have a valid post code please leave the field blank - the webtool will not accept invalid post codes. Enter ‘OVERSEAS’ for non-UK residents. Patient’s post code at usual residence. If patient is admitted from either a 'Holiday residence' or 'Respite care' - use patient’s home post code. If fall occurs during acute hospital care or inpatient rehabilitation then record their home post code. Use the hospital’s post code only for people who sustain their hip fracture while living as a ‘permanent hospital resident’.</td>
</tr>
<tr>
<td>Patient ID/ Hospital number</td>
<td>Free text</td>
<td>Validation in place. Key field-record cannot be Hospital, serial, or other anonymous reference. This is the hospital number assigned. Avoid leading zeroes in the number as these can cause problems.</td>
</tr>
</tbody>
</table>
**Admission fields**

<table>
<thead>
<tr>
<th>Field</th>
<th>Format</th>
<th>Validation</th>
<th>Status</th>
<th>Why required</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital in which fracture is first identified</td>
<td>Select from drop down list</td>
<td>One option only</td>
<td>Optional</td>
<td>This allows the audit to determine if the patient is treated in the same hospital as diagnosis of the fracture takes place.</td>
<td>The hospital where the patient first presents, even if they are transferred somewhere else for treatment.</td>
</tr>
<tr>
<td>Residence before this hospital admission</td>
<td>Select from drop down list</td>
<td>One option only</td>
<td>Mandatory</td>
<td>This allows the level of dependence of the patient to be identified. It also allows capture of the incidence of hip fractures resulting from</td>
<td></td>
</tr>
</tbody>
</table>
### Admission with hip fracture via A&E

<table>
<thead>
<tr>
<th>Description</th>
<th>Input Format</th>
<th>Validation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission with hip fracture via A&amp;E</td>
<td>Select from drop down list</td>
<td>One option only</td>
<td>Optional</td>
</tr>
<tr>
<td>This identifies which patients are admitted as emergencies and which patients are already inpatients.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Date & time of admission to A&E (inpatient falls seen by trauma team)

<table>
<thead>
<tr>
<th>Description</th>
<th>Input Format</th>
<th>Validation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date &amp; time of admission to A&amp;E (inpatient falls seen by trauma team)</td>
<td>dd/mm/yyyy hh:mm</td>
<td>Valid date/time</td>
<td>Mandatory, used for BPT</td>
</tr>
<tr>
<td>This is the time that the clock starts for all timed assessments/treatments. Record the date and time of arrival in A&amp;E department of operating hospital. For patients fracturing in hospital, record date and time of presentation to trauma team. For patients admitted via A&amp;E the time can be found on the A&amp;E admission card. For individuals who fall as inpatients, please use the date and time recorded in the notes by the trauma doctor. If this cannot be found, use the date and time on the X-ray taken after the patient fell. To ensure the correct date and time is entered into this field, please refer to the scenarios below.*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Admitted to orthopaedic/orthogeriatric ward?

<table>
<thead>
<tr>
<th>Description</th>
<th>Input Format</th>
<th>Validation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to orthopaedic/orthogeriatric ward?</td>
<td>Yes/No</td>
<td>One option only</td>
<td>Optional</td>
</tr>
<tr>
<td>This determines any patients who are never admitted to an orthopaedic or orthogeriatric ward. Includes dedicated geriatrician-staffed hip fracture or orthogeriatric wards as</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Date/time of admission to orthopaedic/orthogeriatric ward | dd/mm/yyyy hh:mm | Valid date/time | Mandatory | This information is used to measure the percentage of patients admitted to specialist care within 4 hours of admission.

This field will not be available if the answer to ‘Admitted to orthopaedic/Orthogeriatric ward?’ is ‘No’.

Use the time recorded as patient arrived on ward, or first timed entry following patient’s arrival on a designated hip fracture ward. For patients who are already on an orthopaedic ward when they fall, their treatment plan will change radically once a hip fracture is diagnosed – one minute should be added to the date and time seen by the trauma team and entered in this field. Do not use the time patient leaves A&E plus ½ hr. | as conventional orthopaedic/trauma wards. |
<table>
<thead>
<tr>
<th><strong>Admitted using jointly agreed assessment protocol</strong></th>
<th>Yes/No</th>
<th>One option only</th>
<th>Used for BPT</th>
<th>This is a requirement of BPT and is recommended as part of the hip fracture programme central to NICE CG124.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orthopaedic GMC number</strong></td>
<td>Select from drop down list</td>
<td>Validated as either 6 or 7 digit number or one letter and 6 or 7 digits.</td>
<td>Mandatory, used for BPT</td>
<td>Submission of this information provides proof that the patient is treated under joint care and that both parties have been involved in the production of</td>
</tr>
</tbody>
</table>
the jointly agreed assessment protocol (NICE standard and BPT requirement).

Geriatrician (Orthogeriatrician) GMC number  Select from drop down list  Validated as either 6 or 7 digit number or one letter and 6 or 7 digits.  Mandatory, used for BPT  Submission of this information provides proof that the patient is treated under joint care.

*Scenarios*

**Scenario 1:** Patient admitted with hip pain - no fracture is identified on initial X-ray. Subsequent imaging by MRI/CT shows a fracture – time of first presentation to A&E should be entered, or original time seen by trauma team in the case of a person falling while they are an inpatient.

**Scenario 2:** Fracture missed at initial assessment, and is not identified on clinical examination, however the radiology report records a fracture – time of first presentation to A&E should be used, or original time seen by the trauma team in the case of a person who has fallen as an inpatient.

**Scenario 3:** An impacted or old fracture is treated conservatively but the patient is unable to mobilise – the time of first presentation to A&E should be used, or original time seen by the trauma team in the case of a person who has fallen as an inpatient.

**Assessment Fields**

<table>
<thead>
<tr>
<th>Field</th>
<th>Format</th>
<th>Validation</th>
<th>Status</th>
<th>Why required</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-fracture mobility</td>
<td>Select from drop down list</td>
<td>One option only</td>
<td>Optional</td>
<td>Poor mobility is often a predictor of poor prognosis and this field is one of those used in the casemix adjustment of mortality. It is also used as part of the CCG outcomes indicator set.</td>
<td>The physiotherapy team may help to provide accurate information for this field.</td>
</tr>
<tr>
<td>Nutritional risk assessment performed on admission</td>
<td>Select from drop down list</td>
<td>One option only</td>
<td>Optional</td>
<td>This field records whether a clinical evaluation of the patient’s nutritional status has been made.</td>
<td>Sites may use whatever assessment tool they prefer and are advised to discuss with their dieticians how best to record the assessment results using this field’s options. If you perform the nutritional assessment several times, please record the first assessment after admission.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Abbreviated Mental Test Scores (AMTS) pre op</td>
<td>Select from drop down list</td>
<td>One option only</td>
<td>Used for BPT</td>
<td>This field records whether an assessment of a patient’s cognitive function has taken place. It is part of the BPT criteria.</td>
<td>The pre-op assessment should be made on admission. Pre-op AMT scores may be low for a number of reasons such as infection, pain or opiate intoxication.</td>
</tr>
<tr>
<td>Abbreviated Mental Test Scores (AMTS) post op</td>
<td>Select from drop down list</td>
<td>One option only</td>
<td>Used for BPT</td>
<td>This field records whether assessment of a patient’s cognitive function has taken place. It is a factor for BPT attainment.</td>
<td>It is advised that the post-op assessment is carried out 4-5 days after surgery to allow the patient to stabilise after anaesthetic. Post-op AMT score may be affected adversely by delirium, hypovolaemia, etc.</td>
</tr>
<tr>
<td>Delirium assessment (in the week following surgery)</td>
<td>Select from drop down list</td>
<td>One option only</td>
<td>Optional</td>
<td>Sites should use the 4AT assessment tool to</td>
<td>This should be carried out in the week following surgery. If</td>
</tr>
</tbody>
</table>
evaluate the presence of delirium. the assessment is performed more than once, please record the first assessment after surgery.

**Side of fracture**
- **Select option**
- **One option only**
- **Key field**
- **cannot be saved until this field is completed.**

This ensures that only the primary hip fracture is recorded. Only one record per side should be entered.

If a patient fractures both sides, please enter a separate record for each hip.

This field is used to generate the unique label for the record and prevent duplication.

**Type of fracture**
- **Select from drop down list**
- **One option only**
- **Mandatory**

The combination of fracture type and operation type is triangulated and unlikely combinations are flagged in the exceptions report.

NHFD only collects data on hip fractures (ICD 10 codes S72.0, S72.1 and S72.2). It is recommended that this information is taken from the operation notes completed by a senior orthopaedic surgeon or by checking X-rays.

**Pathological**
- **Select from drop down list**
- **One option only**
- **Mandatory**

This is collected to monitor trends in pathological fractures and atypical fractures

Both primary and secondary malignancy affecting the hip fracture should be recorded, as well as ‘atypical’ fractures. ‘Atypical’ fractures are associated with specific drug treatments and the presence of these fractures should be corroborated by the
orthopaedic surgeon.
Select ‘Malignancy’ only if primary or secondary malignancy is present at the fracture site
Select ‘Atypical’ if the fracture is linked to antiresorptive/bisphosphonate use.

<table>
<thead>
<tr>
<th>Treatment fields</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Field</strong></td>
</tr>
<tr>
<td>ASA grade</td>
</tr>
<tr>
<td>Date &amp; time of primary surgery</td>
</tr>
<tr>
<td>Field</td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Operation performed</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Type of anaesthesia</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Grade of senior surgeon present in room</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
supervising the operation. (electronic or paper) – this individual will be either:
• Performing the procedure: completes the procedure from start to finish
• Assisting with the procedure: performs the key components of the procedure
• Supervising, scrubbed: the trainee performs all or key components of the procedure with the trainer scrubbed
• Supervising, unscrubbed: the trainer is unscrubbed and is in the operating theatre throughout or in the operating theatre suite and regularly enters the operating theatre during the procedure (70% of the duration of the procedure)

| Grade of senior anaesthetist present in the operating room | Select from drop down list | One option only | Optional | This is used to monitor the grade of most senior anaesthetist present. | A site should record the most senior anaesthetist present in the operating room as noted on the |
theatre record (electronic or paper) – if this is not the performing anaesthetist then a senior supervising anaesthetist should:

- be present in the theatre suite
- be easily contactable and must be available to attend within two minutes of being requested to attend by the PA(A)
- be present in the anaesthetic room/operating theatre during induction of anaesthesia
- regularly review the intra-operative anaesthetic management
- be present during emergence from anaesthesia until the patient has been handed over safely to the recovery staff
- remain in the theatre suite until control of airway reflexes has returned and
artificial airway devices have been removed, or the ongoing care of the patient has been handed on to other appropriately qualified staff, eg in the intensive care unit.

<table>
<thead>
<tr>
<th>Reason if delay &gt; 36 hours</th>
<th>Select from drop down list</th>
<th>One option only</th>
<th>Mandatory</th>
<th>This is used to determine whether surgical delays are clinical or administrative in nature.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcers</td>
<td>Yes/No/Unknown</td>
<td>One option only</td>
<td>Mandatory</td>
<td>This is used to monitor rates of hospital acquired pressure ulcers – an important measure of patient safety and quality of care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>All patients should be regularly assessed for the presence of pressure ulcers. NHFD only collects data on pressure ulcers (of grade 2 or above) which occur during the acute admission.</td>
</tr>
<tr>
<td>Date &amp; time assessed by geriatrician</td>
<td>dd/mm/yyyy hh:mm</td>
<td>Valid date</td>
<td>Mandatory, used for BPT</td>
<td>This is used to calculate whether a perioperative geriatric assessment is made in line with NICE guidance (defined by BPT as 72 hours)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Record the date and time of the first geriatrician entry in the notes following diagnosis of the hip fracture. If the patient is already under the care of a geriatrician but then sustains a hip fracture after a fall in</td>
</tr>
</tbody>
</table>
hospital, their plan of care will be altered. Please enter the patient’s first review after the hip fracture in this field.

<table>
<thead>
<tr>
<th>Geriatrician grade</th>
<th>Select from drop down list</th>
<th>One option only</th>
<th>Mandatory, required for BPT</th>
<th>This is used to determine whether geriatric assessments are performed by suitably senior staff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist falls assessment</td>
<td>Select from drop down list</td>
<td>One option only</td>
<td>Mandatory, required for BPT</td>
<td>All patients should be assessed for the risk of future falls. This is a component of BPT compliance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>This is defined as a systematic assessment by a suitably trained person e.g. geriatrician or a specialist assessment trained nurse, which must cover the following domains:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- falls history (noting previous falls)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- cause of index fall (including medication review)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- risk factors for falling and injury (including fracture)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- from this information a plan of action to prevent further</td>
</tr>
<tr>
<td>Multidisciplinary rehabilitation team assessment</td>
<td>Yes/No/Unknown</td>
<td>One option only</td>
<td>Mandatory, required for BPT</td>
<td>This is part of the BPT criteria.</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>----------------</td>
<td>----------------</td>
<td>-----------------------------</td>
<td>---------------------------------</td>
</tr>
</tbody>
</table>

Defined as ‘a group of people of different professions (and including as a minimum a physiotherapist, occupational therapist, nurse and doctor) with job plan responsibilities for the assessment and treatment of hip fracture patients, and who convene (including face to face or virtual ward round) regularly (at least weekly) to discuss patient treatment and care, and plan shared clinical care goals’.

<table>
<thead>
<tr>
<th>Bone protection medication</th>
<th>Select from drop down list</th>
<th>One option only</th>
<th>Mandatory, required for BPT</th>
<th>All patients should be assessed for the need to commence or continue medication to strengthen osteoporotic bone, thus reducing the risk of future fractures. This is a component of BPT and is part of NICE guidance.</th>
</tr>
</thead>
</table>

A very small number of patients will be assessed and bone medication will not be prescribed for medical reasons; however, the vast majority of patients should be offered some form of bone strengthening medication. A comprehensive list of these...
medications can be found in the FAQs section of the NHFD website.
Calcium and vitamin D supplements are not considered effective as bone strengthening medication and should not be recorded as such.

<table>
<thead>
<tr>
<th>Mobilised on day of or day following surgery</th>
<th>Yes-Physiotherapist/Yes-other ward staff/ No</th>
<th>One option only</th>
<th>Optional</th>
<th>This is collected to measure patterns of mobilisation across the country.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessed by physiotherapist on day of or day after surgery</td>
<td>Yes/No</td>
<td>One option only</td>
<td>Optional</td>
<td>If the patient has been assessed on the day of or the day after surgery then record ‘yes’, whether or not they were able to mobilise.</td>
</tr>
<tr>
<td>Field</td>
<td>Format</td>
<td>Validation</td>
<td>Status</td>
<td>Why required</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>----------------</td>
<td>------------</td>
<td>----------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Date of discharge from acute orthopaedic ward</strong></td>
<td>dd/mm/yyyy</td>
<td>Valid date</td>
<td>Mandatory</td>
<td>This is used to calculate acute length of stay. This field will not be available if the patient was never admitted to an orthopaedic ward.</td>
</tr>
<tr>
<td><strong>Discharge destination from acute orthopaedic ward</strong></td>
<td>Select from drop down list</td>
<td>One option only</td>
<td>Mandatory</td>
<td>This is used to determine whether patients are returning to their usual place of residence. This field is also used to measure length of stay in settings with different rehabilitation arrangements. This field will not be available if the patient was never admitted to an orthopaedic ward.</td>
</tr>
<tr>
<td><strong>Date of final discharge from Trust</strong></td>
<td>dd/mm/yyyy</td>
<td>Valid date</td>
<td>Mandatory</td>
<td>This is used to calculate post-acute and total</td>
</tr>
</tbody>
</table>


The patient may be returning to their previous residence, transferring to CCG-funded rehabilitation, taking up a new care home placement or going into self-funded private care.

| Discharge destination from Trust | Select from drop down list | One option only | Mandatory | This is used to determine whether patients are returning to their usual place of residence. This field is also used to measure length of stay in settings with different rehabilitation arrangements. | If a patient normally resides in a care home then this should be recorded as such, not the patient’s own home. ‘Own home’ should only be used if a patient returns to independent living accommodation. |

Please note the following examples

- Example 1: If a patient is discharged from the acute ward directly to their previous residence (own home/care home) the date/time and destinations for both discharge fields will be the same.
- Example 2: If a patient is moved from the acute ward to a rehabilitation ward within the hospital, then transferred to a rehabilitation facility at a community hospital before returning to their previous residence (own home/care home) the date/time and destination for the discharge fields will be different.
Follow-up fields

Patient follow-up at 120 days is important for measuring patient related outcomes, and also contributes data to the CCG outcomes indicators. It is important that this field is completed even though it involves recording information downstream of the initial care episode.

<table>
<thead>
<tr>
<th>Field</th>
<th>Format</th>
<th>Validation</th>
<th>Status</th>
<th>Why required</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date patient contacted</td>
<td>dd/mm/yyyy</td>
<td>Valid date</td>
<td>Optional</td>
<td>To record when follow-up contact was made.</td>
<td>Use ‘Patient could not be contacted’ box if contact was attempted but unsuccessful.</td>
</tr>
<tr>
<td>Residential status</td>
<td>Select from drop down list</td>
<td>One option only</td>
<td>Optional</td>
<td>To determine whether patients are returning to their pre-fracture place of residence.</td>
<td>If a patient normally resides in a care home then this should be recorded as such, not the patient’s own home. ‘Own home’ should only be used if a patient returns to independent living accommodation.</td>
</tr>
<tr>
<td>Mobility</td>
<td>Select from drop down list</td>
<td>One option only</td>
<td>Optional</td>
<td>To determine whether patients are returning to their pre-fracture mobility.</td>
<td>The options correspond to those in the admission section of the dataset.</td>
</tr>
<tr>
<td>Bone protection medication</td>
<td>Select from drop down list</td>
<td>One option only</td>
<td>Optional</td>
<td>This field measures the number of patients who were prescribed bone.</td>
<td></td>
</tr>
<tr>
<td><strong>Reoperation within 120 days of admission to A&amp;E</strong></td>
<td>Select from drop down list</td>
<td>One option only</td>
<td>Optional</td>
<td>This field collects data on patients that needed a second operation within 120 days. This has a profound effect on recovery and prognosis.</td>
<td>If there is more than one reoperation within this time period, only record the most significant procedure.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

protection medication and remain compliant with treatment.
Creating custom fields

Please note that this feature is only available to hospitals using the webtool to submit data on a patient-by-patient basis, it is not available for hospitals that undertake bulk uploads of data in CSV format.

The NHFD dataset is designed to collect specific data on all patients based on casemix, process and outcomes. We are aware that individual hospitals may wish to collect additional data for local analysis and as such we have provided the facility to create custom fields to append the database.

A maximum of 20 additional fields are available and each additional field created will appear under the ‘Other’ tab in the patient record.

To create a new custom field:

1. From the main home page, click on the ‘More’ tab at the top of the screen.
2. Click on ‘My custom fields’ on the right hand menu, which opens a new page.
3. Click on ‘New field profile’ at the top of the page.
4. Enter the field label, which is the description of what data you wish to record in this field (eg patients on clopidogrel).
5. Choose field name from the dropdown box, eg ‘Userfield 1’. Please note that a maximum of 20 custom fields can be added.
6. Enter field type – the options are text, number, date or drop down list.
   If you select drop down list, enter the options you wish to be available. The field will default to the first answer in this list, so you are advised to have a blank option at the top of the list to avoid confusion, and ensure that users have to choose the correct option. Use the space bar for the first option, hit the return key to move to the next line and type the second option in. Enter all the options like this.
7. Specify whether you want this field included in your hip fracture records.
8. For the field order choose the appropriate number from the drop down menu that corresponds with the field name, ie ‘Userfield01’ should have field number 1.
9. ‘Field help, comments or notes’ is a free text box to help users fill in the custom field (this can be left blank).
10. Click ‘save’ and ‘close’.

The additional custom field will now appear in each new record created. In addition, for those that export data, you will have the option to include the custom field in your export.

If at any time you turn off a custom field (by selecting ‘no’ to ‘Include this field in your Hip Fracture records?’), the information will remain on records already submitted whilst that custom field was active.
Please note that once a custom field has been created it cannot be changed. If you wish to delete a custom field you will need to contact the NHFD (nhfd@rcplondon.ac.uk), but be aware that if a custom field is removed completely, all data recorded in that field while it was active will be lost.

My Clinicians

This tool ensures that the correct GMC number is inserted next to a clinician’s name when selected from the drop down list.

- From the home page select the ‘More’ tab
- Select ‘My Clinicians’ from the left side menu. This opens a list of clinicians already recorded at your hospital
- Click on ‘New Clinician’ at the top of the page and fill in the appropriate name, GMC number and job title
- Select ‘yes’ to ‘Show in selection list’, save and close
- The new clinician will now appear in the drop down list of clinicians on the patient record. When the name is selected the GMC number will automatically populate that field.

To remove a clinician from the drop down list

If a clinician no longer participates in hip fracture care go to that clinician’s record, click ‘Edit’ and then select ‘no’ in ‘Show in selection list’. This will stop the clinician’s name appearing in your drop down box but ensures that their name remains attached to historic records.

Please do not overwrite an existing clinician’s details with those of a new clinician, as this will overwrite their details in all existing records. Always create a new clinician, and remove old ones simply by selecting ‘no’ to ‘Show in selection list’.
Data quality

Checking and correcting exceptions and unlikely combinations

There are certain built-in checks on the webtool to ensure that the data entered is as accurate as possible. These include sense checking of timelines, NHS number and post code validation etc. When you try and save a record, a box listing any problems will appear to help you correct any inaccuracies—this will flag anything the system deems impossible or incorrect (e.g., date of surgery before date of admission).

The exceptions report is the system’s way of highlighting any records that contain data that are unlikely but could be correct. These require verification or correction as appropriate.

The report can be found in the ‘Reports’ tab under ‘Exceptions’ in the left side menu.

The exceptions reported on are:

- **Unlikely combinations** – fracture type and operation performed
- **Time to orthopaedic ward > 500 hrs** – from admission to A&E
- **Time to surgery > 450 hrs** – from admission to A&E
- **Time to discharge > 200 days** – from admission to A&E to discharge from the Trust

This does not mean that the data entered are incorrect, just that they are very unusual and should be checked.

The exceptions report should be checked at least monthly; check that dates and times are correct and in the case of unlikely combinations, check the X-rays and notes to see if the data are correct. Lead clinicians should assist if necessary.

Unlikely combinations

Open the record by clicking on the operation performed. At the top of the record you will see the following:

**Exception: Unlikely surgical procedure**

Click 'Edit' and a check box will appear:

**Exception: Unlikely surgical procedure** ☑ Is this correct?

If the data are correct tick the box. Save and close the record and it will be removed from the exceptions report. If the data are incorrect, edit the record with the correct information. Save and close the record and it will disappear from the exceptions report (as long as there are no further exceptions within the record). Other exceptions can be dealt with in the same manner.
Deleting records and removing duplicates

The NHFD only collects the primary fracture for each hip, with each fracture recorded separately. (So if a patient fractures both hips at once, please enter one record per hip.) The minimum age for inclusion in the NHFD is 60 years (at the time of admission). Subsequent admissions for the same hip should not be recorded in the database. If entered, these will appear as duplicates.

To find any duplicate records, go to the ‘Reports’ tab and then the exceptions reports. At the bottom of the list is the duplicates report, which contains all of these records.

You can remove duplicates and any other records that shouldn’t be part of the audit by deleting them. First review the details to make sure you have the correct record.

1. Open the record and click the ‘Delete’ button in the top right of the screen
2. Select the reason for the deletion and click ‘Yes’ to confirm, then click the ‘Delete’ button.

Any record can be restored within 30 days of it being deleted:

1. Open the ‘Deleted patients’ list in the ‘Patient Data’ menu and find the record you wish to restore
2. Open the record and click the ‘Restore’ button in the top right of the screen
3. Confirm you wish to restore the record, then click the ‘Restore’ button. The deleted record will appear in your patient records as before it was deleted.

After 30 days, any deleted records will be permanently removed and cannot be restored.

If you need to restore permanently deleted records after 30 days, you should contact the Crown helpdesk.
Importing and exporting data

Uploading data from an existing database

Some hospitals have computer software such as Bluespier or existing local hip fracture databases. In these cases it is often easier to upload data files of multiple patients at one time to the NHFD. There is a provision within the website to accommodate this by importing files saved in comma separated value (CSV) format.

1. Go to the ‘Import Data’ tab and select a file to import by clicking ‘Browse’. Please note data needs to be in a CSV file for import.

2. Select the correct file type for the version 8 or 9 dataset (v8 is for patients admitted up to 31 December 2015, v9 is for those admitted from 1 January 2016).

3. Import files may have a descriptive line on the first row of the file called a 'header row' or just 'headings'. This column headings row contains labels or descriptions of the data stored in the column underneath it, rather than actual data, and so they can be 'skipped' by the import process. Please check whether there are column headings in your data file, as if you select ‘yes’ and your data has no column headings, the first line of data will be ignored. If you select ‘no’ and there are column headings, this will produce errors in the import log.

4. Click ‘Import’

Once you have imported the file, you can use the import files and import logs to check the success of your import. Click on ‘Import files’ to view a list of all of your imports.
Click on ‘Import logs’ to view the list with a column stating whether the import was successful, including any files that failed to import. Open the import log (click on the date, highlighted in blue) to see the details of the records.

When you open the import log, the record totals section (yellow box) will show you:

- **New records added to the database:** records that do not already exist in the NHFD (defined by hospital, hospital number/patient ID and fracture side).
- **Existing records updated:** records already in the system but with some differing data to what’s imported. The existing data is replaced with the new import data.
- **Identical records skipped:** records that already exist and all data matches what is in the import.
- **Rejected records:** records with ‘fatal errors’ that prevent them from being uploaded.

Errors in the import data are categorised:

- **Minor error:** the record is imported, but some mandatory data are missing/invalid.
- **Serious error:** the record is imported, but only as a draft record as some of the mandatory fields are missing/invalid.
- **Fatal errors:** the record cannot be imported at all.
The ‘Errors and warnings’ section at the bottom of the screen gives the specific reason for a record’s import failure. Serious errors are in blue and fatal errors are in red.

If necessary, you can correct any errors and re-import the file. The record totals box will show the updates.

**Exporting Data**

All data submitted to the NHFD can be exported in a spread sheet.

Data are normally exported for one of two reasons:

1. To be used for local analysis
2. For re-importing changes in a data file by those hospitals that bulk upload their data.
Click the ‘Export Data’ tab.

Select the export format:

- Use 'Ready for Import' to export data, correct or update information and then re-import the updated file.
- Use 'Include calculated fields' if using the file for further analysis.
- Use ‘Include custom fields’ if you would like to include your custom fields in the export (these are locally designated fields, set up by some sites to collect additional data. These data are not used by the NHFD and can only be viewed by the sites that create them.)

Live data are held in three files:

1. V7 contains records for patients admitted between 01/04/2011 and 31/03/2014
2. V8 contains records for patients admitted between 01/04/2014 and 31/12/2015
3. V9 contains records for patients admitted from 01/01/2016 onwards.

The archive file contains records for patients admitted before 01/04/2011.

Select whether you want live or archive data and the dataset version. Then select whether you want to export the whole of that dataset, or specify a range of admission dates to export. Remember that the date selection needs to match the corresponding dataset version. To export data from a period of time spanning more than one dataset version, you will need to do each an export for each dataset version separately.
Example: To export data from the time period 01/01/2011–01/05/2014, export first from the archive file, inserting dates 01/01/2011 to 31/3/2011.

Secondly export from the live file selecting v7 and inserting dates 01/04/2011 to 31/03/2014.

Lastly export from the live file selecting v8 and inserting dates 01/04/2014 to 01/05/2014.

Spread sheets should be combined with great caution as each file contains a different number of columns, due to the changes in the dataset.

Once all fields are complete click ‘export’.

A prompt will appear to either open or save your spread sheet.

The spread sheet is in CSV format, so if you wish to save the data on a local computer for analysis select ‘Excel workbook’ in the ‘Save as’ option. If you are exporting your data for re-import, it is advisable to keep the spread sheet in CSV format. Changing the format can corrupt some numerical data (e.g. patient hospital numbers beginning with zero. Excel will strip out the primary zero and when re-imported the record will be seen as new patient.)
NHFD online reporting

Online monthly report

To allow data to be used in a timely manner we produce a monthly report online. This allows monitoring of local performance and benchmarking against both regional and national performance.

To access this report:

- select the ‘Reports’ tab from the home page
- on the map click on your region and then select your hospital from the list that is displayed – you can only see hospital level data at your site (if you work at more than one site, you will be able to access the data for whichever site you are logged into)
- select the report month. This will show figures for that month or, if you select ‘Annual Report’, it will show figures for the year ending in that month (so to view figures for March 2015-February 2016, select, select 2016-02′ as the Report Month). Click on ‘Monthly Report’ and ‘Annual Report’ to switch between the two views.

Local: the hospital you collect data for
SHA: the region surrounding your hospital
National: all hospitals in England, Wales and Northern Ireland.

This report is updated every 4 hours.

Important notes on this report:

- This report is very simplistic with no analysis or cleansing of data performed
• With the various changes made to the dataset there are some fields that cannot be reported on in this report, as some fields have been removed or amended.

Online run charts

Click on the ‘Charts’ tab on the homepage to access your hospital’s charts. Underneath each chart is a link to the chart details (‘About this chart and how to use it’), which gives an explanation of what the chart shows, what data is used and definitions of all the lines.

On the menu on the left of the screen, click on each chart to view.

If you hold your mouse over any point on a line on the chart, a yellow box will appear, giving the numbers shown at that point in time.
Each chart can be customised:

- Toggle each line on or off by clicking on the line’s label underneath the chart.

- Zoom in on a particular time period by clicking and dragging your mouse on the chart, across the time you would like to view. To revert to the original view, click ‘Reset zoom’ in the top right corner.

- The charts can be downloaded from the website - click on the menu button in the top right corner and select the format you want to export it in.

These charts are updated every hour, so when you add or amend a record it will be included as the charts are refreshed. The charts show data up to the last complete month but one, to give time for data checking by inputters and to avoid displaying small numbers.

**Best practice tariff report (England only)**

Best practice tariff is an uplift of £1,335 paid for each patient whose care meets certain criteria, such as having surgery within 36 hours of admission and having certain assessments performed.

Go to ‘BPT report’ to view your patients and whether each aspect of their care met the criteria for payment of BPT. Each criterion of BPT is displayed and if it has not been achieved then the field will be highlighted in red.

Patients will only appear in this report once they have been discharged from the Trust, as this marks the point when all treatment and assessments have been completed. (This is the only report where patients appear in the quarter they are discharged— all other NHFD reporting is based on admission date.)
To access this report select the ‘Report’ tab from the homepage and then ‘BPT report’ from the left side menu. Select the appropriate quarter from the drop down menu at the top of the report. You can also select how many records are displayed per page.

The report can be exported in spreadsheet format (click the ‘Export’ button at the bottom of the page) but the red cells on the screen will not be shaded in the spreadsheet.

NHFD data is directly extracted from the database by Data Services for Commissioners Regional Offices (DSCROs), matched to a valid CCG code, validated against Secondary Uses Service (SUS) data and then reported to commissioners for payment of BPT to hospitals.

Facilities audit

Each year the NHFD requests the submission of information about the services/facilities available at your hospital. These data allow the NHFD to map the progress of hip fracture units and allows other hospitals to see where improvements can be made.

The NHFD notifies users when the facilities audit is open for completion and the submission deadline. Submission of a completed facilities audit is mandatory for inclusion in the NHFD annual report.
To access the facilities audit:

- From the home page, select ‘Facilities Audit’ on the left side menu
- Complete each field
- Enter the data. Any registered user at a site can enter data, and users can log in and enter data on as many occasions as necessary. Ensure you click ‘Save’ after each addition of data
- Once all the data are entered and saved, tick ‘Mark as complete’. This will lock the audit. If you do this accidentally or need to amend any data after you have marked it complete, please contact the NHFD (nhfd@rcplondon.ac.uk) to have it unlocked.

Completion of the facilities audit is a requirement for a hospital’s inclusion in the annual report.
NHFD annual reports

All of the NHFD’s reports, past and present, are available on the home page of the NHFD website (www.nhfd.co.uk) and you do not need to log in to access them.

NHFD annual report
Released in September each year, aimed primarily at clinicians, managers, chief executives and policymakers. Presents analysis of participating sites’ performance against NICE guidelines and quality standards and recommendations for clinicians.

NHFD commissioners’ report
Released in December. Aimed primarily at CCGs and related stakeholders, includes performance (listed by CCG) of participating sites against NICE guidelines, and recommendations for commissioning of hip fracture services.

NHFD patient report: My Hip Fracture Care
Aimed at patients, their family and carers. The report takes the form of 12 questions patients are encouraged to ask those treating them, with the intention of increasing their understanding of their injury and letting them know what to expect while they are in hospital.

Hard copies are available free of charge and hospitals are encouraged to hand these out to their patients. Please email nhfd@rcplondon.ac.uk with how many copies you would like, your name and the address you would like them sent to.
Information governance

Data are collected and processed with specific approval of the Secretary of State for Health on the recommendation of the Health Research Authority (HRA) Confidentiality Advisory Group (CAG) under the Health Service (Control of Patient Information) Regulations 2002. This is more commonly referred to as section 251 approval and references to 'section 251 support or approval' actually refer to approval given under the authority of the Regulations. The CAG reference number of NHFD is CAG 8-03(PR11)/2013

Section 251 was established to enable the common law duty of confidentiality to be overridden to enable disclosure of confidential patient information for medical purposes, where it was not possible to use anonymised information and where seeking consent was not practical with regard to the cost and technology available.

Personal confidential data items for this audit are processed by Crown Informatics under section 251 approval prior to anonymisation and transfer to the Royal College of Surgeons Clinical Effectiveness Unit for analysis. Reported data and data files released under government transparency guidance are managed in line with UK statistics authority guidance on the handling of small numbers to prevent the identification of individuals. Data for English hospitals included in all provider level charts in this report can be found at www.data.gov.uk/