Royal College of Physicians | NHFD

National Hip Fracture Database (NHFD) **Facilities Survey 2019**

In January 2019 we contacted all 175 trauma units in England, Wales and Northern Ireland with our annual survey of facilities against which we measure performance in each hospital. A total of 170 (97 %) units responded. **Detailed responses** are available on the **NHFD website**.

Supporting clinical governance

NHFD is a quality improvement (QI) platform hospitals use to drive up performance. Key to this is the monthly governance meeting in which care, outcome and patient feedback can be reviewed.

All responding units reported holding such meetings, over 90 % of which have a formal agenda. The data illustrates that meetings are multidisciplinary in nature, and usually attended by management staff. All units reported using data from the NHFD website, with over 80 % of units reported using NHFD data to guide both their governance meetings and local QI/research projects. (Fig 1)

The NHFD is designed to encourage teams to follow recommendations from the National Institute for Health and Care Excellence (NICE), and past NHFD reports have highlighted inspiring examples of innovative practice.

Services around the country are following these leads and most have established protocols that anticipate common clinically important issues (Fig 2).

The **resources** section of the NHFD website includes examples of admission assessment protocols and bundles, and most units have adopted some form of these.

Fig 1

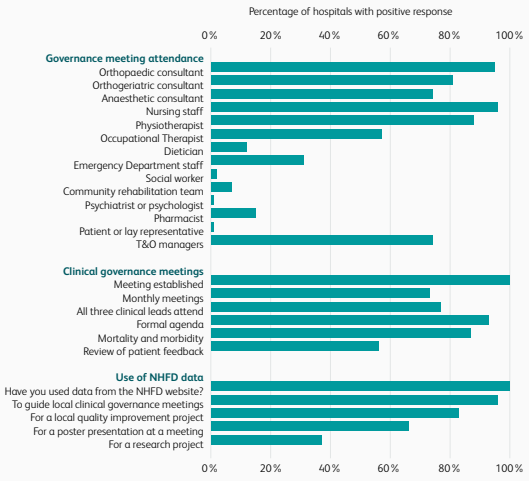
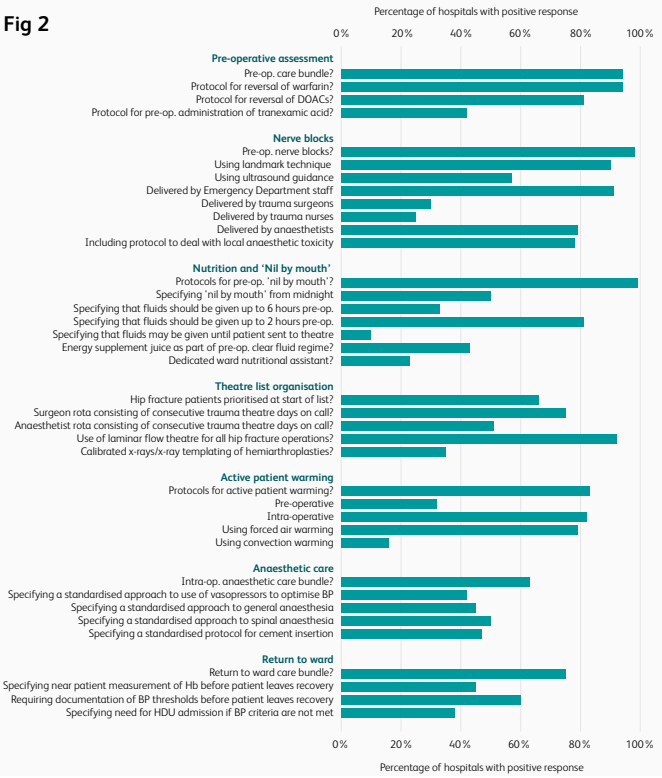


Fig 2



In association with

British Geriatrics Society — Improving healthcare for older people
British Orthopaedic Association
Royal Osteoporosis Society — Better bone health for everybody

Commissioned by

Public Health England
HQIP — Healthcare Quality Improvement Partnership

Encouraging service improvement (Fig 2)

Anticoagulation needs particular attention in the perioperative period and most units have protocols to ensure the safe reversal of warfarin and the newer anticoagulant drugs (**Taranu *et al***). The NHFD has promoted nerve blocks to ease patients' pain while they are waiting for, and recovering from, surgery. Over half of patients now receive a block before going to theatre.

Teams should develop protocols that ensure that all appropriate patients can be offered a nerve block as soon as possible after diagnosis, minimising their need for opioid analgesia. Most units now have protocols and care bundles to standardise assessment, 'nil by mouth' policies, active patient warming, perioperative anaesthetic care, and safe return to the ward from recovery. Examples are given in our **resources** section. The role of nutritional support is widely recognised and was central to **HipQIP** work in Northumbria. This project included attention to minimising preoperative starvation times and employing dedicated ward nutritional assistants. Use of pre- and perioperative warming to avoid hypothermia is recommended by NICE, and has been shown to decrease infection rates (**Melling *et al***). Preoperative ward-based active warming should be offered if a patient's temperature is <36°C (NICE CG65, 2016). Most hospitals now have warming protocols, but only a third offer this in the preoperative period.

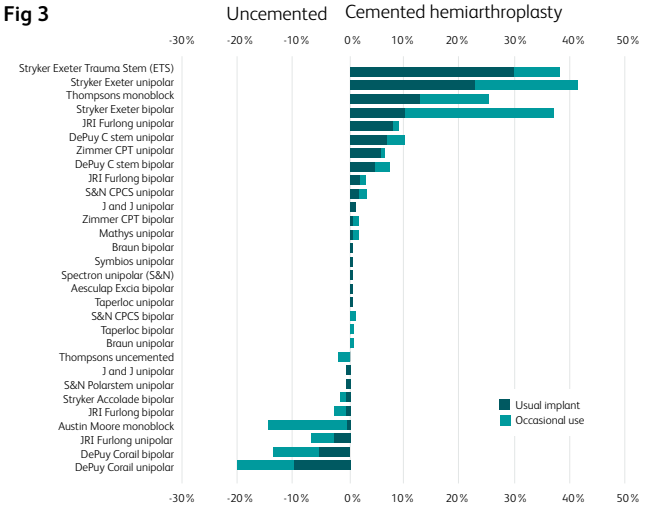
Data from the NHFD website is used to guide the British Orthopaedic Association (BOA) led multidisciplinary service reviews when requested by hospitals striving to improve local hip fracture care for their patients. These reviews have been welcomed by multiple hospital teams over several years to aid service improvement, particularly when local 30 day mortality rates have been higher than expected, to help identify areas in need of development or added resources.

Understanding variation in hemiarthroplasty surgery (Fig 3)

Half of hip fracture patients sustain displaced intracapsular hip fractures, and since most are ineligible for total hip arthroplasty, hemiarthroplasty remains the commonest operation recorded by the NHFD.

Hemiarthroplasty implant data are not recorded in the National Joint Registry (NJR), so this year we asked hospitals to indicate the types of implant they usually used, and those which they occasionally employed (Fig 3).

Fig 3



95% of hospitals reported cemented implants as their prosthesis of choice. There was, however, significant variation in implant usage across the country.

Despite the NICE recommendation of cement fixation of hemiarthroplasties, several hospitals still use uncemented stems. Eight hospitals (5%) exclusively or predominantly use uncemented implants.

This national variation in implant usage has significant cost implications without proven clinical benefit (as exemplified in the recent WHiTE3 study, (**Sims *et al***), and we would encourage hospitals to review their hemiarthroplasty implant inventory accordingly.

Monitoring changes in staffing and service organisation (Figs 4 and 5)

The facilities survey helps to understand changes in staffing since the NHFD was established in 2007. Orthogeriatric support has been key to the NHFD's success in improving outcomes (**Neuburger *et al* 2015, 2017**). Each year hospitals have been asked how many hours per week of senior orthogeriatric trauma or hip fracture ward time they had. Fig 4 shows that the extent of such support continues to increase – from an average of 4 hours per patient in 2014 to 5.5 hours in 2018.

There is still huge variation in the amount of orthogeriatric support around the country, with several units reporting no senior orthogeriatrician time available. Five out of these are in Wales, where orthogeriatric provision is not incentivised by Best Practice Tariff. In three units in England there was no orthogeriatrician time noted due to unfulfilled vacancies.

Orthogeriatrician time is spread across the whole week, particularly in the mornings (Fig 5), with only a few units having access to weekend support.

Fig 4

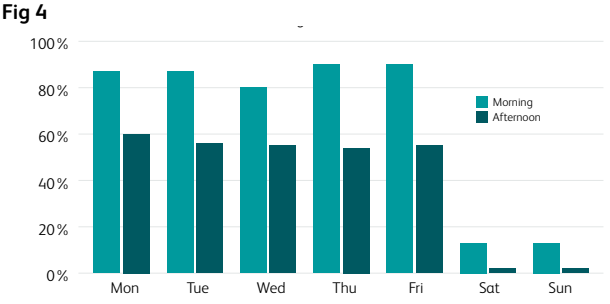


Fig 5