This is a Management Information publication

Published management information are non-official statistics which may be in the process of being transitioned into official statistics. They may not comply with the UK Statistics Authority’s Code of Practice with regard to high data quality or high public value but there is a public interest or a specific interest by a specialist user group in accessing these statistics as there are no associated official statistics available.

Users should therefore be aware of the aspects of data quality and caveats surrounding these data, all of which are listed in this document.


Many thanks to Anna and Kathleen Sweeney for supplying the cover photo and for sharing their personal experiences of hip fracture.
# Contents

Foreword 2

Introduction 3

Key Results: Achievement of Scottish Standards of Care for Hip Fracture Patients in 2018 5

Achieving the Scottish Standards of Care for Hip Fracture Patients 2018 6

Audit Results 9

Appendices 38

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 1</td>
<td>Background information</td>
<td>38</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Hospital abbreviations and data completeness</td>
<td>39</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>Members of the Scottish Hip Fracture Audit and Steering Group</td>
<td>40</td>
</tr>
<tr>
<td>Appendix 4</td>
<td>Local Audit Coordinators</td>
<td>41</td>
</tr>
<tr>
<td>Appendix 5</td>
<td>Early access details</td>
<td>43</td>
</tr>
<tr>
<td>Appendix 6</td>
<td>ISD and Official Statistics</td>
<td>44</td>
</tr>
<tr>
<td>Appendix 7</td>
<td>Contact details</td>
<td>45</td>
</tr>
<tr>
<td>Appendix 8</td>
<td>Access to the Trauma and Orthopaedic Dashboard</td>
<td>46</td>
</tr>
<tr>
<td>Appendix 9</td>
<td>Chief Executive Officer responses</td>
<td>47</td>
</tr>
</tbody>
</table>
Foreword

In April 2019, my 4th Annual Report on Realistic Medicine focussed on the principle of Building a Personalised Approach to Care. This approach involves working collaboratively to overcome the challenges in our health system to personalise care and treatment for our patients, provided in a way which is also meaningful for our staff. The Standards of Care for patients who sustain a hip fracture is a good example of the requirement for this focus.

The concept of understanding people is key to the optimal management of patients with fragility fractures. These patients have often been previously independent at home. Their primary aim is therefore to return home as soon as possible following their acute hospital admission. The established quality pathway for hip fracture patients and its measures have improved the patient experience and outcomes with timely surgery and reducing delays to discharge, all of which contribute to the likelihood of their return to prior levels of independence. Delays within the pathway process increase the future levels of dependency for the patient and create inefficiencies within the whole system. The detailed achievements and challenges of this are clear within the published report.

In 2018 we also launched the Scottish Atlas of Healthcare Variation. The aims of this work are similar to those of the Scottish Hip Fracture Audit www.shfa.scot.nhs.uk which seeks to reduce unnecessary variation in practice in order to improve care for patients. The original Scottish Hip Fracture report seven years ago highlighted significant variation in practice across the country and areas for improvement in clinical care. With the development of the audit to now include all hip fracture patients, this variation is reducing and increased adherence to the evidence based clinical guidelines is improving overall care and outcomes for patients across Scotland.

With all these factors in mind, I would ask you all to consider the data within this report and the scope for continued improvements within this established multi-disciplinary pathway for patients who fracture their hip to return home as quickly and safely as possible. There are also areas to consider the further optimisation of care for this vulnerable patient group in ways which prioritise “what matters to them”.

Catherine Calderwood
Chief Medical Officer for Scotland
Introduction

The Scottish Hip Fracture Audit (SHFA) is now in its 7th year since the re-introduction of the audit in 2012/13. This original report highlighted significant variation in practice across the country and a number of important areas for improvement in clinical care. This current document reports on 7146 hip fractures between January and December 2018, representing 96% of all patients admitted during this time period.

I would first of all like to take this opportunity to thank the health care professionals who work in each of the orthopaedic units and associated services around the country. You have all been instrumental in delivering the substantial improvements in patient care. I would also like to acknowledge the National Hip Fracture Steering Group who provide clinical direction to ensure we are focused on care, improvements, research and energy to keep achieving more.

The aim of the SHFA is to improve the quality of care to this patient group in order to provide care which is safe, efficient, best practice and patient centred. This can be difficult in the case of hip fracture patients as they represent a heterogeneous patient group, varying from those who are fit and living independently at the time of injury to those who are often at the end of their lives.

The data presented in the 2019 report highlights a number of areas of ongoing variation and indeed in some cases we have identified a lack or indeed a reversal in the achievement of key performance indicators. The hip fracture care pathway is a complex one involving multi-agency input.

We have identified a continuing trend of increasing ED transfer times which likely reflects the strain which ED departments face across the country. However, we have also observed progress in terms of the number of patients who receive all of the “big 6” assessments/ interventions, although further progress is required particularly in the assessment of delirium. On a much more positive note almost 2 out of 3 patients now receive a fascia iliaca block (FIB) as part of the initial analgesia regime from less than 1 in 10 when the audit began.

We have also observed a reversal in the significant progress that has been made in terms of the inpatient bundle, again as a result mainly of cognition/ delirium assessment. This will be a focus in the coming year to address this issue both on the ward and in the ED.

One of the greatest achievements of the audit has been the improvement in ortho-geriatric provision with almost 85% of patients now undergoing review within 72 hours of admission from less than 20% at the introduction of the audit. Length of stay continues to improve steadily falling from 22 days to 17 days at the current time.

The Standards of Care for Hip Fracture Patients in Scotland has been recently updated and can be found on the SHFA website— www.shfa.scot.nhs.uk.

The governance process has also undergone significant change since the previous audit report with the introduction of the Scottish National Audit Programme Governance Policy. The policy requires units who are 3 standard deviations from the Scottish mean for 5 key performance indicators (including: 30 day mortality, ortho-geriatric assessment, re-admission within 14 days, time to
theatre and home to home within 30 days of admission) to formally review their status and provide a written report to the National Hip Fracture Steering Group outlining their findings as well as detailing what improvements will be made regarding the relevant care pathway. The Steering Group then review these reports and agree if the actions described are sufficient to ensure improvement; if this is not the case then it is possible that the matter be referred to Healthcare Improvement Scotland for further review (details of this process are available within this report) see Appendix 9 for responses from health boards.

We will continue to monitor the effectiveness of this process over the coming months and make changes if required. We at the SHFA Steering Group will continue, with the invaluable assistance of local staff within the orthopaedic departments across Scotland, to work tirelessly to reduce unnecessary variation in practice and to continue to improve the quality of care this vulnerable patient group receives.

Graeme Holt
Orthopaedic Surgeon, Chair of Scottish Hip Fracture Steering Group
Key Results: Achievement of Scottish Standards of Care for Hip Fracture Patients in 2018

Addressing variation in audit results is a key part of achieving sustained improvement. In 2018, wide variation in achievement of the following standards existed between hospitals in Scotland:

2018 • Key Results

- **Delirium screening in ED**: Identifying delirium at the earliest opportunity is a priority as it can be associated with increased length of stay and death.  
  - Lowest: 2%  
  - Highest: 92%

- **Fascia iliaca block use in ED**: Providing early pain relief is essential to improve comfort. An injection into a nerve in the thigh called a fascia iliaca block provides effective relief from pain.  
  - Lowest: 6%  
  - Highest: 85%

- **Osteoporosis risk assessment**: and treatment is important to assist with the prevention of further fractures.  
  - Lowest: 22%  
  - Highest: 94%

- **Comprehensive geriatric assessment**: Many patients presenting with hip fractures are frail and have complex medical problems. Collaborative working with geriatricians has been shown to improve the quality of medical care in this frail group.  
  - Lowest: 0%  
  - Highest: 97%

- **Average length of stay**: 
  - Decreased from 30 days in 2017 to 17 days in 2018.

- **Return more people home safely within 30 days**: 
  - Increased to 60% in 2018.
Achieving the Scottish Standards of Care for Hip Fracture Patients 2018

Achieving the Scottish Standards of Care for Hip Fracture Patients and reducing variation is one of the key outcome measures of the Scottish Hip Fracture Audit. Standardising care for every person who suffers a hip fracture in Scotland is paramount to improving the overall quality of care provided as well as providing equity of care nationally. Over the course of 2018, there was an increased focus on empowering clinical staff to improve achievement of these standards at a local level which included closer working with audit staff to ensure the quality and accuracy of the data collected.

Whilst the following results may not demonstrate huge changes in rates of compliance, the small incremental improvements indicate the continued growing momentum of clinical staff to make local manageable changes to improve care of patients with a hip fracture.

The following standards were in place in 2018 and used as the basis of this report:

---

**Standard 1**  
Patients with a hip fracture should be transferred from the Emergency Department to the orthopaedic ward within 4 hours.

**Standard 2**  
Patients who have a clinical suspicion or confirmation of a hip fracture have the ‘Big Six’ interventions/treatments before leaving the Emergency Department:

1. Provision of pain relief  
2. Screening for delirium  
3. Early Warning Score (EWS) system  
4. Full blood investigation  
5. Intravenous fluids therapy  
6. Pressure area care

**Standard 3**  
Every patient with a hip fracture should receive the ‘inpatient bundle of care’ within 24 hours of admission.

1. Baseline assessment of cognitive function  
2. Falls assessment  
3. Food, fluids and nutritional assessment  
4. Pressure area assessment

**Standard 4**  
Patients must undergo surgical repair of their hip fracture within 36 hours of admission.
Standard 5  No patients should be repeatedly fasted in preparation for surgery. In addition, oral fluids should be encouraged up to 2 hours prior to surgery.

Standard 6  Pre-operative catheterisation should only be carried out for identified medical reasons and not be used as ‘routine’ practice.

Standard 7  Cemented hemi-arthroplasty implants should be standard unless clinically indicated otherwise.

Standard 8  Every patient who is identified locally as being frail should receive comprehensive geriatric assessment within 3 days of admission.

Standard 9  Mobilisation should have begun by the end of the first day after surgery and every patient should have a physiotherapy assessment by the end of day 2.

Standard 10  Patients with a hip fracture should have an Occupational Therapy (OT) assessment by the end of day 3 post-operatively.

Standard 11  Every patient who has a hip fracture should have an assessment of their bone health prior to leaving the acute orthopaedic ward.

Standard 12  Every patient’s recovery should be optimised by a multi-disciplinary team approach such that they are discharged safely back to their original place of residence within 30 days of admission.

As a result of ongoing and continued consultation with those involved in the care of hip fracture patients and a commitment to continuously improve, a new set of Hip Fracture Standards were introduced from January 2018 and will be reported on in August 2019. The new 2018 Scottish Hip Fracture Standards can be found at www.shfa.scot.nhs.uk/_docs/2018/Scottish-standards-of-care-for-hip-fracture-patients-2018.pdf.
Summary of key changes in the 2018 standards

**Removed (as covered by local guidelines for clinical care of all patients)**

**Standard 6** Pre-operative catheterisation should only be carried out for identified medical reasons and not used as routine practice.

**Amended**

**Standard 10** Every patient has a documented Occupational Therapy assessment commenced by the end of day 3 after admission to the ward.

**Standard 11** Every patient who has a hip fracture has an assessment of, or a referral for, their bone health prior to leaving the acute orthopaedic ward.
Audit Results

This section compares the audit data for each hospital against the Scottish Hip Fracture Care Standards and highlights national improvements since the 2012/13 audit.

It should be noted the 2016 data collection period only 8 months of data was available whereas 2017 and 2018 are full years of data. Comparisons can, however, still be made.

**Standard 1** Patients with a hip fracture should be transferred from the Emergency Department (ED) to the orthopaedic ward within four hours.

**Rationale** Following clinical confirmation or diagnosis of a hip fracture, local protocols should ensure the efficient and safe transfer of the patient to an orthopaedic ward. This transfer should not be delayed by a requirement that the patient is reviewed by the receiving orthopaedic team in ED unless diagnostic uncertainty exists. Unless indicated for essential medical interventions, these frail elderly patients should not have an extended stay in an ED as this represents a delay to the area of definitive care.

**Fig. 1.1 Time in Emergency Department**

The majority of Scottish hospitals were able to transfer patients with a hip fracture to a ward within four hours of arrival at the Emergency Department (ED) (87%). However, this represents a decrease from 90% in 2017 and below the current national Accident and Emergency waiting time standard of 95%. Two hospitals (RIE and Forth Valley) achieved less than 80% being seen and transferred within 4 hours so work is still required to improve patients’ timely transfer to definitive care.
Since 2015/16 there has been a steady increase in patients waiting over 4 hours in ED before transfer for definitive care to an orthopaedic ward, 14% in 2018. Patients waiting between 2 and 4 hours in ED has decreased slightly from last year by 1% but remains high at 75%.
Standard 2

Patients who have a clinical suspicion or confirmation of a hip fracture should have the ‘Big Six’ interventions/treatments before leaving the Emergency Department.

Rationale

Every patient who has clinical suspicion or confirmation of a hip fracture should have the following ‘Big Six’ interventions/treatments in ED (or earlier if an inter-hospital transfer), as part of the local protocol.

» Provision of pain relief
» Screening for delirium
» Early Warning Score (EWS) system
» Full bloods investigation and electrocardiogram
» Intravenous fluid therapy
» Pressure area care

Fig. 2.1 ‘Big Six’ ED interventions/treatments

Despite a 7% increase from 2017, full completion of the ‘Big Six’ bundle of care in ED remains low nationally. The majority of hospitals are achieving less than 50% compliance with this standard with considerable variation between the best and worst hospitals. Improvement in delivery of the ED ‘Big Six’ bundle is a focus of the Steering Group in 2019.

» Crosshouse continues to improve completion of the ‘Big Six’ bundle and are highest performing hospital at 85% completion for 2018.
» Queen Elizabeth University Hospital (QEUH), Royal Infirmary Edinburgh (RIE) and Aberdeen remain the lowest performing hospitals and continue to show little improvement.
» NHS Tayside (Ninewells and Perth) continue to adopt their own protocol.
It is widely acknowledged that early screening to identify the presence of delirium is an essential step in managing and improving the outcomes for people who develop this condition. However, there remain wide variations across Scottish Emergency Departments.

- Screening for the presence of delirium in ED was almost never completed in 3 out of 19 hospitals (Aberdeen, Ninewells and Perth).
- Queen Elizabeth University Hospital (QEUH) and Glasgow Royal Infirmary (GRI) have now adopted delirium screening and have shown increases of 28% and 59% respectively.
- Crosshouse and Royal Alexandra Hospital (RAH) carried out delirium screening for 90% or more of their patients in 2018.
Full blood investigation

All but 2 hospitals in Scotland take bloods in ED. The exception is NHS Tayside hospitals (Ninewells and Perth) who continue to adopt their own protocol. Electrocardiogram is currently captured by the audit but not measured as part of the standard.

Intravenous fluids therapy

Initiation of intravenous fluid therapy in ED remains variable across Scotland. Work has been carried out in 2018 to focus on hydration and Fig 2.3 demonstrates improvement in some hospitals but with further work required in others to ensure that patients are optimally hydrated prior to surgery.

Pressure areas recorded

Recorded inspection of pressure areas again varies widely across Scotland. It continues to be low at 58% of patients, with particularly poor performance documented in Fife (24%) and Wishaw (26%).
The use of nerve blocks as the optimal method of pain relief for hip fracture patients continues to increase across all sites from 48% (2017) to 63% (2018).
Every patient with a hip fracture should receive the ‘inpatient bundle of care’ within 24 hours of admission.

Rationale
The inpatient care bundle must be completed within 24 hours of admission to the orthopaedic/receiving ward. These assessments (cognitive, fall, nutritional and pressure area risk assessments), as well as the subsequent interventions, are essential to maximise the quality of care and overall patient outcome through a multi-disciplinary approach to patient care. Involvement with patients and relatives/carers is essential.

Completion of the inpatient assessment bundle within 24 hours of admission to the ward has decreased in 2018 to 57% of patients, down from 75% in 2017. The decrease was mirrored across all hospitals for the bundle of care. This is concerning as previously there had been year on year increases from 2012/13. There was a very slight improvement in pressure area assessment overall, but a reduction in the percentage of patients receiving cognitive screening, falls and nutritional assessments within 24 hours of admission has resulted in an overall reduction in the number of patients receiving the full bundle of care.
Fig. 3.2  Inpatient assessments by type

- Cognition assessment
- Falls assessment
- Nutritional assessment
- Pressure areas assessment

Percentage of patients

Sites included:
- All Sites 12/13 (1387)
- All Sites 15/16 (1041)
- All Sites 2016 (3931)
- All Sites 2017 (6650)
- All Sites 2018 (7092)
Standard 4  Patients must undergo surgical repair of their hip fracture within 36 hours of admission.

Rationale
It is essential that surgical fixation of a hip fracture is expedited. Delayed fixation correlates with increased mortality at one year, increased complications and increased hospital stay. Hospitals must therefore be organised in such a way that facilitates timely and planned surgery without delays, meaning not only adequate theatre capacity for trauma surgery and availability of anaesthetists and surgeons, but also a means of rapidly assessing and optimising frail, elderly patients with multiple co-morbidities.

Fig. 4.1  Time to theatre for all patients

Across Scotland, 72% of patients had surgical repair of their hip fracture within the recommended 36 hours following admission. This is a slight increase from 2017 though achievement of this standard has not changed significantly over the past few years. Less than 60% of patients were taken to theatre within 36 hours of admission in Forth Valley, Crosshouse, Fife and Western Isles. The Royal Infirmary of Edinburgh has continued their upward trend and are now just below the Scotland mean at 69%.
Surgery within 36 hours

NHS Ayrshire & Arran is taking forward a major review of Trauma Services in line with the national direction to create a single Trauma Unit in Ayrshire and a separate Elective Care Centre of Excellence. The audit and review data established through the review of the 2018 Scottish Hip Fracture Audit provides useful information and evidence which will be considered as part of that process. Further improvements will be driven through that process and are anticipated as follows: Trauma theatre capacity will be increased at UHC, As an interim measure, a case will be made for increased trauma theatre capacity at UHC to deliver all-day trauma theatre capacity 365 days a year as well as a second anaesthetist to support the earlier start of trauma. There will be increased focus on the trauma theatre start time, and reasons for delay. Outcomes from the audit of medically unfit. Delays in diagnosis due to weekend CT/MRI access are being addressed.

NHS Ayrshire & Arran • University Hospital Crosshouse

‘Records of the outliers were requested from the SHFA. These were then correlated to the local audit data collected by SHFA Audit nurse. 26.3% of patients were delayed due to lack of theatre. The remainder were delayed for medical reasons and a range of miscellaneous reasons, a small proportion of which were avoidable. NHS Fife had already identified lack of trauma theatre time as a cause for delays in getting acute hip fractures to theatre. Since January 2019 an additional two am trauma lists have been added and other work ongoing includes looking at identifying high risk acute hip fracture patients to ensure they are appropriately assessed in a view to minimising the risk of cancellations.’

NHS Fife • Victoria Infirmary
‘The challenges to deliver this measure of care include improved management of “spikes” in trauma activity that impact on time to theatre, improved trauma capacity for the weekend when there are reduced resources and the management of sub-specialty areas of trauma (e.g. upper limb) which can impact on other trauma case management. A monthly hip fracture MDT meeting takes place, part of the remit of this group is to review the patient exceptions who did not meet the hip fracture standards.’

NHS Forth Valley • Forth Valley Royal Hospital

‘A large number of the patients delayed to theatre were unavoidable. We have also taken on board the information we have been provided for some of the other reason of the delays and putting measures in place to avoid delays as possible in the future. It was noted that UH Hairmyres was not an outlier for repeated fasting.’

NHS Lanarkshire • University Hospital Hairmyres

Fig. 4.1.a Percentage of patients having surgical repair within 36 hours
The vast majority of patients who were not operated on within the recommended 36 hours were either medically unfit to undergo a procedure (41%) or were unable to be taken for surgery due to lack of theatre time (41%). Rapid optimisation and proactive anticoagulation management is encouraged to reduce the amount of patients who are deemed medically unfit.
**Standard 5**

No patients should be repeatedly fasted in preparation for surgery. In addition, oral fluids should be encouraged up to two hours prior to surgery.

**Rationale**

Repeating fasting cycles occur when patients are fasted for surgery and then cancelled, and this results in limited oral intake over a number of days. This should be avoided with careful and realistic planning of theatre lists and ensuring adequate theatre capacity. Communication between the theatre/ward teams and the patient (including relatives/carers) is essential. This collaborative approach can be facilitated through a nurse-led trauma liaison service.

**Fig. 5.1**

*Was fasting cycle repeated?*

Despite an increase in the collection of this data there has been little change to the overall percentage of patients (19%) continuing to have to repeat fast in 2018. Performance across the country varies from Raigmore achieving only 7% of patients repeat fasting compared to Crosshouse Hospital where 36% of patients continue to repeat fast.

Most hospitals continue to find it challenging to co-ordinate theatre planning with ward staff to ensure that patients are not repeatedly fasted or denied oral fluids for extended periods of time. However, some have developed simple solutions to improve this, such as introducing protocols which mean that every patient in the ward is offered a drink at 7am (Crosshouse) or changing fasting prescription from ‘fast from’ to ‘allow fluids until’ (Royal Alexandra Hospital).
Fig. 5.1.a  Percentage of patients fasted only once for surgery
Standard 6  Pre-operative catheterisation should only be carried out for identified medical reasons and not used as ‘routine’ practice.

This standard was removed as a standard during 2017 (as covered by local guidelines for clinical care of all patients) and is therefore no longer being reported routinely.

Standard 7  Cemented hemi-arthroplasty implants should be standard unless clinically indicated otherwise.

Rationale  Use of cemented hemi-arthroplasty implants should be standard, as recommended by NICE (CG124/SIGN111) unless specifically contra-indicated by significant operative risk. The patient’s pre-existing ambulatory status should be a consideration when selecting the type of implant.

Fig. 7.1  Hemi-arthroplasty – use of cement

Cemented implants were used in 92% of hip fracture patients in 2018. Seventeen out of 19 hospitals use cemented implants in more than 80% of cases with the exceptions being Crosshouse (79%) and Raigmore Hospital (38%). Raigmore Hospital has adopted a different policy for type of device used resulting in the low number of patients receiving cemented implants there.
Forty-seven percent of patients received a hemi-arthroplasty with 33% of patients receiving pin and plate, accounting for just over 86% of the procedures carried out on hip fracture patients.
Standard 8

Every patient who is identified locally as being frail should receive comprehensive geriatric assessment within three days of admission.

Rationale

Many patients presenting with hip fractures are frail and have complex medical problems. Collaborative working with Geriatricians has been shown to improve the standards of medical care in this frail group.

Fig. 8.1

Time until comprehensive geriatric assessment

Nationally time until comprehensive geriatric assessment (CGA) continues to improve year on year with 84% of patients receiving a CGA on or within 3 days of admission to hospital with a hip fracture. However, some areas of the country continue to struggle to deliver this service to their patients, with Ayr, Crosshouse, Elgin and Western Isles continuing to perform considerably below the national average. Wishaw has made the biggest improvement since last year, 50% in 2017 to 89% in 2018.

Fig. 8.1.a

Percentage of patients who had a comprehensive geriatric assessment within three days of admission
Comprehensive geriatric assessment (CGA)

‘The medical staffing situation in the care of the elderly department remains very challenging. Multiple attempts to recruit to these vacant posts have been unsuccessful. As a result, support to the orthopaedic ward has not been possible resulting in the 0% result in the audit. Attempts to recruit more consultants are ongoing. The use of ACE practitioners to undertake the assessments is currently being explored though requires support from care of the elderly department and there are meetings planned to address this aspect of the hip fracture pathway which will be a key component to the success of the reconfigured orthopaedic service in Ayrshire.’

NHS Ayrshire and Arran • University Hospital Crosshouse and University Hospital Ayr

‘A review of these patients’ pathways was carried out by the local audit nurse, data analysts and was discussed with the ortho geriatrician. The current level of geriatrician input into orthopaedics is acknowledged as not sufficient enough to review every patient within 3 days of admission. This has been identified as part of the ongoing local improvement work and the team are exploring the options available. The use of frailty screening within orthopaedics is also being discussed and will be explored further during 2019. The establishment of a frailty pathway in orthopaedics is part of ongoing whole system discussions.’

NHS Dumfries and Galloway • Dumfries and Galloway Royal Infirmary

‘During the last 12 months Dr Gray’s has had a dedicated Acute Care of the Elderly assessment unit (ACE), within the medical ward. This did initially result in improving the Comprehensive Geriatric Assessments being completed within the 3 days of admission, this however was person dependent and compliance was significantly reduced due to staff sickness. The subsequent appointment of 2 Advanced Nurse Practitioners will support improvement in this area.’

NHS Grampian • Dr Gray’s Hospital
‘Prior to 2018 there was no formal Geriatrician or specialist nurse input to the IRH orthopaedic wards to undertake CGA. In early 2018 with the support from the Access team, 2 Elderly Care Orthopaedic Nurses (ECON’s) were been employed. Following this appointment of the ECON’s IRH data has improved consistently and since September 2018 has been over 90%, rising to 100% performance in March 2019. A multi professional team approach to CGA will be adopted at the IRH site with the introduction of Consultant Geriatrician sessions in July 2019.’

NHS Greater Glasgow and Clyde • Inverclyde Royal Hospital

‘Undertaking a Comprehensive Geriatric Assessment within three days has and remains a significant challenge for NHS Western Isles, following the loss of the Locum Consultant Geriatrician we do not have any dedicated Orthogeriatrician, Consultant Geriatrician, geriatric services or obligate network. The loss of the Locum Consultant Geriatrician has resulted in NHS Western Isles revisiting and developing a new service model. A frailty group was convened in April 2018 which will include geriatric services and an MDT approach to completing CGA.’

NHS Western Isles • Western isles Hospital
Standard 9

**Mobilisation should have begun by the end of the first post-operative day and every patient should have a physiotherapy assessment by the end of day two.**

**Rationale**

Early mobilisation, in combination with post-operative physiotherapy, may be of value in reducing pulmonary complications, optimising early recovery and reducing falls. If the patient’s overall medical condition allows, mobilisation and multidisciplinary rehabilitation should begin by the first post-operative day.

![Mobilisation Graph](image)

Early mobilisation following surgical repair is widely accepted as being an important factor in returning people to as near to pre-fracture function as possible, with 68% of all patients being mobilised within one day of surgery in 2018, a slight decrease from 69% in 2017. Reasons for delaying mobilisation beyond the first postoperative day may include poor pain control or delayed recovery from anaesthetic, but delays caused by these factors would be expected to be seen consistently across the country. Therefore other confounding factors could have influenced the variation and should be explored locally, particularly in: Ayr, Borders, Elgin, Hairmyres and Wishaw where less than 60% of patients were mobilised by the end of the first post-operative day. Lessons may be learned from Raigmore Hospital who mobilised 89% of their patients on the first post-operative day.
Involvement of the physiotherapy team early in the post-operative recovery period is also widely accepted as being an important factor in fulfilling people’s maximum recovery potential. All hospitals had some form of physiotherapy involvement within 2 days for 80% of patients. Hairmyres (83%) and Western Isles (81%) were the lowest performing hospitals.
Standard 10  All patients with a hip fracture should have an Occupational Therapy (OT) assessment by the end of day three post-operatively.

Rationale  Occupational Therapy (OT) contributes to both enabling patients to regain function post-operatively and assessing the need for support following discharge. It is likely that OT input will continue in rehabilitation settings and inform the on-going discharge processes. Patients being discharged to their own home or care home can also benefit from OT input. The communication link between OT services in secondary and primary/community care is essential so that patients can return to their original place of residence with confidence and support, this being the preferred model rather than traditional rehabilitation in NHS facilities.

Fig. 10.1  Time from surgery until seen by OT

Patients being seen by an Occupational Therapist within 3 days of admission to hospital continues to improve year on year across Scotland. The majority of hospitals have more than 75% of patients seen within 3 days. However RIE (53%) and Western Isles (51%) struggle to deliver this standard performing well below the national average (76%) with Ayr (22%) and Crosshouse (13%) continuing to remain the lowest performing hospitals in Scotland.
Fig. 10.1a  Percentage of patients having OT assessment by the end of the third day post-op
Standard 11 Every patient who has a hip fracture should have an assessment of their bone health prior to leaving the acute orthopaedic ward.

Rationale Osteoporosis risk assessment and treatment is integral to the prevention of further fractures alongside falls prevention strategies.

Fig. 11.1 Bone health assessment

National variation in bone health assessment continues in 2018 from 22% in the Western Isles to 97% in Royal Alexandra Hospital with the national average being 89%. The national average has been static since 2015/16. Elgin (26%) and Western Isles (22%) are the lowest performing hospitals.

Fig. 11.1.a Percentage of patients having bone health actions undertaken or planned
Standard 12  Every patient’s care and recovery should be optimised by a multidisciplinary team approach such that they are discharged safely back to their original place of residence within 30 days of admission.

Rationale  The main aim of the Hip Fracture Care Workstrand is “to get patients back to their original place of residence as rapidly as possible, whilst optimising their ability to retain their independence”. This should be achieved by optimising the pathway of care during their actual hospital stay and a seamless and supported transition back to the original place of residence within 30 days of admission.

Fig. 12.1  Percentage of patients admitted from home or a care home who were again resident there at 30 days post-admission

The principle focus continues to be the safe return of patients to their original place of residence within 30 days of sustaining a hip fracture. Returning to the patient’s original place of residence quickly is reported as one of the most important outcomes to both patients and relatives. Where possible, rehabilitation should be carried out at home supported by family and/or community services. Many NHS rehabilitation sites have less OT and PT input than the acute inpatient ward and often have no OT/PT input at the weekend. Lengthy hospital and rehabilitation stays in NHS facilities can unintentionally hinder both patient and relative confidence and overall wellbeing. The median length of total stay is still variable across Scotland ranging from 13 days in Raigmore to 23 days in Ayr and Aberdeen. However in 2018, 17 of the 19 hospitals discharged patients to their original place of residence in under 20 days, an increase from 12 hospitals in 2017.
Proportion of patients who returned home within 30 days

Currently in NHS Grampian, there is a lack of support within the community to help support patients in their own homes. Rehabilitation beds are used to help the patient progress to back to place of origin. Grampian has access to rehabilitation beds in rural areas nearer the patient’s homes. We have no influence or control over community support and resources and therefore have no option other than to direct patients into rehabilitation facilities to allow patient flow though the Trauma Unit. We believe rehabilitation is a positive step for recovering patients and should not be seen as negative as is suggested in the report, as the data from our centre shows that we have one of the lowest readmission rates (4th in Scotland).

NHS Grampian • Aberdeen Royal Infirmary

Fig. 12.2  Median length of acute orthopaedic stay by discharge destination

Sample sizes (own home/ care home/ rehab) are given in brackets. Medians reflect normal practice and, compared to mean values, are less likely to be influenced by a small number of patients with lengthy admissions as a result of specific medical problems.
Fig. 12.3  **Median length of total hospital stay**

![Median length of total hospital stay graph](image)

- Median +/- 25 and 75 percentiles

Fig. 12.4  **Discharge destination**

![Discharge destination graph](image)

- Home/sheltered
- Care home
- Rehab
- Other
- Died (in acute care)

*‘Other’ includes patients discharged to acute hospital and NHS continuing care, and also those not yet discharged from the acute orthopaedic ward by 60 days post-admission.*
Fig. 12.5  Percentage of patients who were re-admitted within 14 days of hospital discharge

Perth (15.2%) and Borders (14.6%) hospitals had the highest rate of re-admission within 14 days of discharge from hospital. Eleven hospitals re-admission rates were between 6% and 10%, with the remaining 6 hospitals having less than 5% re-admission within 14 days of discharge from hospital.

Readmission within 14 days
'We undertook a case notes review of every patient readmitted. Each set of case notes was reviewed by a senior clinician and sought to look at reason for readmission and whether or not we felt this could have been mitigated from discharge planning from the previous episode.
NHS Borders • Borders General Hospital

'We have completed full assessment of readmissions with a review of notes, radiographs and electronic records. This was undertaken by clinicians with support of audit practitioners helping with data and clinicians engaging in review, of medical records. We will continue to look at our service improvements to enhance the quality of care to patients with hip fractures and you find the summary of our case series review of satisfactory standard.'
NHS Tayside • Perth Royal Infirmary

**Thirty-day post-admission hip fracture patient mortality**

The mortality of hip fracture patients at 30 days after admission is shown in the chart below. Hospitals that lie outwith 2 standard deviations from the mean are outliers from other hospitals. For 2018, no hospitals have been identified as outliers. However it has been noted that Dumfries and Galloway and Hairmyres are both touching the 2SD line. They have been informed of this and it has been suggested that they may want to review this locally according to the current Scottish National Audit Programme governance policy.
Each hospital in Scotland contributes to the Scottish Hip Fracture Audit and, where possible, data is collected for all eligible patients. Where full completion is not possible, care is taken to ensure that the submitted data is not biased in any way.

Data is collected by a locally employed ‘Local Audit Coordinator’ who is responsible for ensuring the accuracy and robustness of the data as well as raising awareness of results to support a continuous improvement process.

A copy of the audit proforma and definitions can be accessed at www.shfa.scot.nhs.uk/About/index.html.

Audit data is updated on a monthly basis, before or soon after the 15th of each month. Anyone who is employed by the NHS or Scottish Government, subject to local approval, can request access to the data which is held on the Trauma & Orthopaedic Portal (see appendix 8).

In order to facilitate the monthly review of progress in achieving the national standards of care, hospitals are provided with an ‘exceptions list’ containing details of all patients who did not achieve a particular standard. Where a small number of cases have not achieved a standard, this may require individual case review. However where multiple patients have not achieved a standard this usually indicates an issue with a process. Hospitals are expected to review this information on a regular basis to identify and agree actions and improvements with the local multidisciplinary team. An example report can be accessed at www.shfa.scot.nhs.uk/Quality-Improvement/index.html.

It should be noted the 2016 data collection period only 8 months of data was available whereas 2017 and 2018 are full years of data. Comparisons can, however, still be made.
Appendix 2  Hospital abbreviations and data completeness

The table below reports the number of patients audited from January to December 2018 and included in this report, and the number of known hip fracture admissions not audited during the same time period.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Number of known hip fractures</th>
<th>Hip fracture admissions not audited</th>
<th>% audited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayr University Hospital Ayr</td>
<td>200</td>
<td>17</td>
<td>92%</td>
</tr>
<tr>
<td>Crosshouse University Hospital Crosshouse</td>
<td>284</td>
<td>22</td>
<td>92%</td>
</tr>
<tr>
<td>BGH Borders General Hospital</td>
<td>175</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>DGRI Dumfries &amp; Galloway Royal Infirmary</td>
<td>274</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Fife Victoria Hospital</td>
<td>440</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Forth Valley Forth Valley Royal Hospital</td>
<td>464</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Aberdeen Aberdeen Royal Infirmary</td>
<td>576</td>
<td>50</td>
<td>91%</td>
</tr>
<tr>
<td>Elgin Dr Gray’s Hospital</td>
<td>149</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>GRI Glasgow Royal Infirmary</td>
<td>502</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>QEUH Glasgow Queen Elizabeth Royal University Hospital</td>
<td>765</td>
<td>112</td>
<td>85%</td>
</tr>
<tr>
<td>RAH Royal Alexandra Hospital</td>
<td>438</td>
<td>31</td>
<td>93%</td>
</tr>
<tr>
<td>Inverclyde Inverclyde Royal Hospital</td>
<td>203</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Raigmore Raigmore Hospital</td>
<td>334</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Hairmyres University Hospital Hairmyres</td>
<td>314</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Wishaw University Hospital Wishaw</td>
<td>441</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>RIE Royal Infirmary of Edinburgh</td>
<td>1,089</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Ninewells Ninewells Hospital</td>
<td>512</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Perth Perth Royal Hospital</td>
<td>182</td>
<td>11</td>
<td>94%</td>
</tr>
<tr>
<td>Western Isles Western Isles Hospital</td>
<td>50</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td><strong>All Sites</strong></td>
<td><strong>7,392</strong></td>
<td><strong>246</strong></td>
<td><strong>97%</strong></td>
</tr>
</tbody>
</table>

Throughout the text and Figures, hospitals are referred to by a shortened version of their name. This is familiar to clinicians and managers for brevity, but also used because of requests for individual hospitals or because it better describes the overall orthopaedic and multi-disciplinary service run by the surgical hospital.
Appendix 3  Members of the Scottish Hip Fracture Audit and Steering Group

Graeme Holt  |  Chairman, Consultant orthopaedic surgeon  
NHS Ayrshire and Arran  
Graeme.holt@aapct.scot.nhs.uk

Kirsty Ward  |  National Clinical Coordinator, MSk Audit  
National Services Scotland, ISD  
Kirstyward@nhs.net

Karen Adam  |  National Clinical Improvement Advisor  
Scottish Government  
Karen.Adam@gov.scot

Kate James  |  National Programme Lead T&O  
Scottish Government  
Kate.James@gov.scot

Rik Smith  |  Senior analyst, MSk Audit  
National Services Scotland, ISD  
RSmith11@nhs.net

Jon Antrobus  |  Consultant Anaesthetist  
NHS Borders  
Jonathan.Antrobus@borders.scot.nhs.uk

Kathleen Ferguson  |  Consultant anaesthetist  
NHS Grampian  
kathleen.ferguson@nhs.net

Mayrine Fraser  |  National Development Manager/Specialist Nurse  
National Osteoporosis Society  
M.Fraser@nos.org.uk

Rashid Abu-Rajab  |  Consultant orthopaedic surgeon  
NHS Greater Glasgow and Clyde  
Rashid.Abu-Rajab@ggc.scot.nhs.uk

Krishna Murthy  |  Consultant Emergency Medicine  
NHS Lothian  
Krishna.Murthy@nhslothian.scot.nhs.uk

Ruth Houson  |  Advanced Nurse Practitioner  
NHS Ayrshire and Arran  
Ruth.Houson@aapct.scot.nhs.uk

Ann Murray  |  Falls programme manager  
NHS Ayrshire and Arran  
ann.murray3@nhs.net

Ann-Marie Owens  |  Trauma Liaison Nurse  
NHS Greater Glasgow and Clyde  
AnneMarie.Owens@ggc.scot.nhs.uk

Angela Stewart  |  Advanced Nurse Practitioner  
NHS Ayrshire and Arran  
Angela.Stewart@aapct.scot.nhs.uk

Hazel Dodds  |  Senior Nurse, Scottish Healthcare Audits  
National Services Scotland, ISD  
hazeldodds@nhs.net

Ann Murdoch  |  Senior Social Worker  
NHS Lothian  
anm55@hotmail.co.uk

Catherine Nivison  |  Chief Allied Health Professional  
NHS Greater Glasgow and Clyde  
Catherine.Nivison@ggc.scot.nhs.uk

Fiona Graham  |  GP in orthopaedic rehabilitation  
NHS Dumfries and Galloway  
fionagraham2@nhs.net

Claire Rae  |  Physiotherapy Manager  
NHS Lanarkshire  
Claire.Rae@lanarkshire.scot.nhs.uk

Gillian Walker  |  Senior Occupational Therapist  
NHS Lothian  
gillian.e.walker@nhslothian.scot.nhs.uk

Seng Wong  |  Foundation Doctor  
NHS Tayside  
sengwong@nhs.net

Liz Burleigh  |  Consultant, Medicine for the Elderly  
NHS Greater Glasgow and Clyde  
Liz.Burleigh@ggc.scot.nhs.uk
Appendix 4

Local Audit Coordinators

Aberdeen Royal Infirmary
Carol Carnegie/Claire Stewart  nhsg.mskaudit@nhs.net

University Hospital Ayr
Shirley Fisher  shirley.fisher@aapct.scot.nhs.uk

Borders General Hospital
Alistair Johnston  alistair.johnston@borders.scot.nhs.uk

University Hospital Crosshouse
Shirley Fisher  shirley.fisher@aapct.scot.nhs.uk

Dumfries & Galloway Royal Infirmary
Jean Bell  jean.bell@nhs.net

Dr Grays Hospital, Elgin
Kenny McKenna  Kenneth.mckenna@nhs.net

Forth Valley Royal Hospital
Jean Brewster  jean.brewster@nhs.net

Glasgow Royal Infirmary
Grace Collins  grace.collins@ggc.scot.nhs.uk

University Hospital Hairmyres
Liz Rundell  elizabeth.rundell@lanarkshire.scot.nhs.uk

Inverclyde Royal Hospital
Mairi Galbraith  mairi.galbraith@ggc.scot.nhs.uk

Ninewells Hospital
Jenny Scott  jenniferscott@nhs.net

Perth Royal Infirmary
Heather Webster  heather.webster@nhs.net

Queen Elizabeth University Hospital
Stephanie Muirhead  stephanie.muirhead@ggc.scot.nhs.uk
Jonathon Steele  jonathon.steele@ggc.scot.nhs.uk

Raigmore Hospital
Pamela McKay  pamela.mckay@nhs.net

Royal Alexandra Hospital
Jacqueline McStay  jackie.mcstay@ggc.scot.nhs.uk
Acknowledgements

This report could not have been prepared without the dedicated work of the Local Audit Coordinators who tirelessly collected and validated this information and provided an essential link role between audit and clinical staff to close the improvement audit loop.
Appendix 5  Early access details

Pre-Release Access

Under terms of the “Pre-Release Access to Official Statistics (Scotland) Order 2008”, ISD is obliged to publish information on those receiving Pre-Release Access (‘Pre-Release Access’ refers to statistics in their final form prior to publication). The standard maximum Pre-Release Access is five working days. Shown below are details of those receiving standard Pre-Release Access.

Standard Pre-Release Access:

Scottish Government Health Department

NHS Board Chief Executives

NHS Board Communication leads

Early Access for Management Information

These statistics will also have been made available to those who needed access to ‘management information’ as part of the delivery of health and care.

Early Access for Quality Assurance

These statistics will also have been made available to those who needed access to help quality assure the publication.
Appendix 6 ISD and Official Statistics

About ISD

Scotland has some of the best health service data in the world combining high quality, consistency, national coverage and the ability to link data to allow patient-based analysis and follow-up.

Information Services Division (ISD) is a business operating unit of NHS National Services Scotland and has been in existence for over 40 years. We are an essential support service to NHS Scotland, the Scottish Government and others, responsive to the needs of NHS Scotland as the delivery of health and social care evolves.

**Purpose:** To deliver effective national and specialist intelligence services to improve the health and wellbeing of people in Scotland.

**Mission:** Better Information, Better Decisions, Better Health

**Vision:** To be a valued partner in improving health and wellbeing in Scotland by providing a world class intelligence service.

Official Statistics

Information Services Division (ISD) is the principal and authoritative source of statistics on health and care services in Scotland. ISD is designated by legislation as a producer of ‘Official Statistics’. Our official statistics publications are produced to a high professional standard and comply with the Code of Practice for Official Statistics. The Code of Practice is produced and monitored by the UK Statistics Authority which is independent of Government. Under the Code of Practice, the format, content and timing of statistics publications are the responsibility of professional staff working within ISD.

ISD’s statistical publications are currently classified as one of the following:

- National Statistics (i.e. assessed by the UK Statistics Authority as complying with the Code of Practice)
- National Statistics (i.e. legacy, still to be assessed by the UK Statistics Authority)
- Official Statistics (i.e. still to be assessed by the UK Statistics Authority)
- Other (not Official Statistics)

Further information on ISD’s statistics, including compliance with the Code of Practice for Official Statistics, and on the UK Statistics Authority, is available on the [ISD website](#).
Appendix 7

Contact details

Kirsty Ward | National Clinical Coordinator
Scottish Hip Fracture Audit
📞 0141 282 2216  📧 Kirstyward@nhs.net

Karen Adam | National Clinical Improvement Advisor
Scottish Government
✉️ Karen.Adam@scotland.gsi.gov.uk

Caroline Martin | Senior Information Analyst
MSk Audit
📞 0141 282 2062  📧 caroline.martin3@nhs.net

Pamela Maclean | Regional Coordinator
MSk Audit
📞 0131 314 1222  📧 pamela.maclean1@nhs.net

The Scottish Hip Fracture Audit and Steering Group would like to thank outgoing member of the group Rik Smith (Senior Information Analyst) for his contribution over the years and wish him well for the future.

For general enquiries regarding the Scottish Hip Fracture Audit please email our generic email address: nss.isdmskaudit@nhs.net and one of the central audit team will respond.
Appendix 8  Access to the Trauma and Orthopaedic Dashboard

Audit data is routinely updated on this web-based platform each month and is provided for multi-disciplinary teams to measure and monitor the sustainability of their improvement actions. To become an approved user of the Trauma & Orthopaedic Portal please go to NSS User Access System. Select “Specialty Information Portal” from the list of products, as this includes the Trauma Orthopaedic Portal.

For help with registration please go to: www.isdscotland.org/Products-and-Services/Datamarts/User-Support.

If you have any issues or questions please contact the team at: NSS.TraumaandOrthopaedicPortal@nhs.net.
Appendix 9  Chief Executive Officer responses

The Chief Executives of each of the Scottish NHS Boards were asked to provide feedback in relation to performance against the National Hip Fracture Standards, particularly those where the Board were performing less well and to outline what activity is in place to improve the care of hip fracture patients locally. Appendix 9 provides an overview of their responses.

NHS Ayrshire & Arran

The issues highlighted by the audit are ones we have been aware of through monitoring the results of the audit. The local hip fracture management group has been revamped recently to keep a closer focus on the management of this specific patient group.

There are three main areas where the data for 2018 demonstrates an area of concern and for the second two—significant outlier status. Time to theatre (SHFA standard 4) has been a challenge on the Crosshouse site for some time and did drift in 2018. A project to look at the utilisation of trauma theatre to improve this has been run and a move to prioritise hip fractures ahead of other patient groups such as children has improved the percentage of patients matching the 36 hour target.

SHFA Standard 7, Comprehensive Geriatric Assessment (CGA) (Ayr 9.4% and Crosshouse 0.4%)

Comprehensive Geriatric Assessment by day three for frail patents. The medical staffing situation in the care of the elderly department remains very challenging. Multiple attempts to recruit to these vacant posts have been unsuccessful. As a result support to the orthopaedic ward has not been possible resulting in the 0% result in the audit. Attempts to recruit more consultants are ongoing. The use of ACE practitioners to undertake the assessments is currently being explored though requires support from care of the elderly department and there are meetings planned to address this aspect of the hip fracture pathway which will be a key component to the success of the reconfigured orthopaedic service in Ayrshire.

SHFA Standard 8, Mobilisation rates by end of first day after surgery (Ayr 52.8%)

The service is committed to increasing the physiotherapy resource within the orthopaedic service. It is planned to recruit physiotherapy assistant and physiotherapy helper hours into the service as soon as the recruitment process is complete.

SHFA Standard 9, Occupational Therapy Assessment (Ayr 22% and Crosshouse 13.5%)

Overall volume of trauma at Crosshouse has been a factor in the senior management decision to assess the implementation of the separation of the trauma and elective services in Ayrshire. Hip fracture management will be based at the Trauma Unit on the Crosshouse site. This should allow improved utilisation of theatre resource with dedicated surgeon to maximise efficiency. Assessment by Occupational Therapist by day 3 has been discussed with the audit facilitator around the strictness of the criteria for marking as undertaken. The hip fracture group will look at this further and liaise with Occupational Therapy but feel this is largely variation in procedural recording.
SHFA Standard 11, Discharge back to original place of residence within 30 days of admission (Ayr 51.5%)

A review of the data has been undertaken showing that a number of patients who have not returned to their original place of residence have been discharged from the acute hospital to a rehabilitation facility for ongoing rehab. The team is committed to improving performance against this standard and will work closely with the multi disciplinary team to support the optimum pathway for each patient.

NHS Borders

SHFA Standard 2, ED ‘Big Six’ (48.5%)

Significant work has gone into meeting this target over the last year and I am pleased to report there has been a sustained, progressive improvement in all ED hip fracture metrics over the last six months. Aggregate data over last 3 months shows that ‘Attainment of all Big 6’ has improved from 48.5% to 74%. Our other ED metrics show ‘time in department <4hrs’ was 95% (national average 85%), nerve blocks 85% (national average 70%). Our ED staff have been congratulated for their hard work.

SHFA Standard 3, Inpatient bundle of care (42.9%)

The importance of these has been discussed at the ward safety briefs. We will monitor compliance on a weekly basis through the Patient Centered Coaching Tool (PCCTs) whereby 5 sets of notes are randomly chosen and assessed for accurate completion of admission assessments amongst other areas of documentation. Our 4AT completion rate has been low. The Ward Manager has also spoken to the OT staff and requested their assistance with the completion of the 4AT assessments which they have agreed to support, and alteration of admission documentation, currently underway, will also improve compliance.

SHFA Standard 8, Mobilisation rates by end of first day after surgery (54.2%)

Our mobilization rates appear to be low, however we are reassured that 93% of our patients underwent physio review within the required timeframe. We believe there are two issues: firstly that the patients have been mobilized but this hasn’t been documented, and secondly that mobilization requires a number of staff to perform safely, and this makes mobilization difficult at periods of high workload or weekends when fewer physios are available. We have focused on improving documentation and recently increased physio equipment to make patient mobilization easier and safer.

SHFA Standard 11, Discharge back to original place of residence within 30 days of admission (48.1%)

We need to reduce reliance on rehab beds for hip fracture patients, and for those admitted to rehab we need to make the patient journey more focused. We have already implemented a number of strategies to try to achieve this:
Hip fracture patients are now being admitted to a number of intermediate care units, which will allow further physio in medically well patients (commenced December 2018), and are now also able to use Hospital At Home services (also around December 2018);

Social Work referrals are now being accepted at a much earlier stage than previously, and fitness for discharge is no longer a requisite for review;

Transformational work has begun through liaison with the Integrated Joint Board, although this remains in an early phase; and

Better liaison between acute and community rehab teams.

We are pleased to report that, although our rate of patients being at home within 30 days (home 30) remains low, our above interventions have made a significant improvement, having increased our home 30 rates from 39% in 2017 to just under 50% in 2018. We will continue to develop a multifaceted strategy to improve our discharge home rates, and fully expect there will be further improvement in 2019.

NHS Dumfries & Galloway

We currently have monthly meetings where we discuss all 11 standards within the Orthopaedic Hip Fracture Care Pathway. There is a multi-disciplinary team attendance at the meetings, including Orthopaedic Surgeon, GP with specialist interest within Geriatric medicine within the acute setting, ED Consultant, Anaesthetist, AHPs, nursing, management and improvement manager. All aspects of the data is discussed with the identification of improvement actions noted and agreed. In response to the Standard 2 & 3 we have been monitoring our progress closely and throughout 2018 improvement actions have been implemented.

SHFA Standard 2, ED ‘Big Six’ (11.1%)

A pro-forma was devised and implemented within the Emergency Department in early 2018. Early engagement was difficult however sustained discussions over the summer resulted in improved clinical ownership. This resulted in a marked improvement with January, February and March 2019 recording an average of 76% adherence to the ‘Big Six’. Work is on-going to embed and sustain performance within the department. A closer working relationship between the audit nurse and ED colleagues has been beneficial in ensuring a more consistent approach to recording. Further to this monthly performance posters are circulated and displayed within the department to promote positive reinforcement.

SHFA Standard 3, Inpatient bundle of care (21.2%)

It is recognised that this is an area of challenge within our hospital. Our main barrier to achieving all 4 assessments is within our ability to complete the delirium screening. Through the regular meetings the need to focus on this standard was recognised and an action plan implemented. Early in 2018 we attempted to use a visual aide for the FY1 to ensure that the 4AT assessment was completed. The improvement was limited however due to the competing priorities that junior doctors are faced with along with the rotational nature of the role. Agreement was gained through the meetings that the nursing staff may be better suited to undertake the screening and therefore we are undertaking training within the ward. Further to this a hip fracture inpatient bundle has been created and is
currently being tested. Three members of the nursing team have been identified as champions and they are liaising and undertaking education sessions with all staff.

In a drive to improve the overall knowledge of the Hip Fracture Standards a Hip Fracture Symposium was held in March. This was well attended from colleagues across the partnership, including guest speakers from the National Hip Fracture Group. There has been increased awareness of the standards, especially within community colleagues where closer working relationships have been fostered to improve the whole patient journey.

**NHS Fife**

**SHFA Standard 2, ED ‘Big Six’ (14.3%)**

Although NHS Fife perform well against many of the acute hip fracture standards, standard 2 is an area where performance has been variable for a number of years. More specifically documentation of cognitive assessment and pressure area review has been inconsistent.

This has been raised through our Acute Hip Fracture MDT Group. The group has representation from our MSk audit nurse, medicine for the elderly, emergency department, orthopaedic surgeons, theatre and ward staff. This standard had been a focus of the group prior to it being highlighted as an area for review in the Hip Fracture Care Report 2019.

Through the groups monthly meetings we have tried various approaches to improve compliance with this standard over the last few years. This included the introduction of a Hip Fracture Fast Track form, which required confirmation that the ‘Big Six’ interventions had been completed prior to transfer to ward. Some aspects of this form have worked well, such as the direct admitting rights from A&E for the medically stable hip fracture patient. However, it failed to achieve sustained attainment of the ‘Big Six’. Cognitive assessment and pressure area assessment being areas where compliance was poorest. More recently IV fluid prescription in A&E has also been variable.

The group had already identified actions around the Big Six which preceded the MSk Audit letter. The group had agreed some action to be taken forward by the Head of nursing for emergency care and emergency department nursing lead. More specifically they identified actions around how the skin checks are undertaken and how this is evidenced within the medical records. There are also actions identified on IV fluids prescription to ensure it is consistent with the standards.

The Emergency Department have a Quality Improvement Group. The ‘Big Six’ attainment is currently being reviewed within this group. The Hip Fracture Dashboard for Standard 2 shows that since the end of 2018, there has been improvement in IV fluid prescribing and in cognitive assessment. Pressure area assessment is part of ongoing work.

Overall we are confident that steps have been taken to address the attainment of the ‘Big Six’ within NHS Fife. Increased awareness of the standard and the impact of ongoing work have already established some improvement since the end of 2018.
NHS Forth Valley

SHFA Standard 2, ED ‘Big Six’ (52.5%)

The Health Board recognises that performance in 1st half of 2018 was poor (28.5%) of patients having all 6 assessments completed, however, this increased to 74% of patients having all 6 assessments completed in the 2nd half of 2018. Performance has averaged 60% in first quarter of 2019. This compares favorably to 32% across Scotland for the same period.

The ED continues to review and reflect on practices in a quality improvement cycle.

Actions to address

Early identification and triage of potential hip fracture patients admitted to the Department and utilising the resuscitation area and the staff allocated. This will allow immediate assessment and management of this group of patients and fast tracking where clinically suitable to the orthopaedic ward.

The Fast Track admission document has been amended over time to reflect feedback from the monthly hip fracture audit group.

The Emergency Department (ED) has identified 2 hip fracture nurse champions to promote the Hip Fracture standards in the ED.

In order to achieve Standard 2, all of the 6 assessments must be completed. An assessment pack has been developed in ED to assist with completion of this assessment.

An Emergency Department Nurse Educator in post since March 2019. One of the tasks for this post is improvement work for management of hip fracture standards relating to ED.

SHFA Standard 4, Patients to theatre within 36 hours of admission (49.9%)

The Health Board recognises that performance in 2018 was poor and has taken actions to address this. The performance in 1st quarter of 2019–January (72%), February (88%) and March 88% is significantly better.

Despite the delays to theatre the 30 day mortality for this patient group is good – with only 4 other Boards in Scotland having better outcomes. The Health Board recognise that delays to theatre

The challenges to deliver this measure of care include improved management of “spikes” in trauma activity that impact on time to theatre, improved trauma capacity for the weekend when there are reduced resources and the management of sub-specialty areas of trauma (e.g. upper limb) which can impact on other trauma case management.

A monthly hip fracture MDT meeting takes place – orthopaedic surgeon, anaesthetist, Emergency Department (ED) consultant, ortho-geriatrician, OT, physiotherapy, nursing staff (from Orthopaedic Ward/ED), Surgical Frailty Advanced Nurse Practitioner, trauma co-ordinator, fracture liaison
practitioner, orthopaedic operational manager and audit co-ordinator. Part of the remit of this group is to review the patient exceptions who did not meet the hip fracture standards.

Actions to address these include:

» The first two cases for the trauma list the following day are agreed the day before by the receiving orthopaedic consultant and the trauma co-ordinator. The theatre list is then circulated to the wider team. This allows anaesthetic review/ intervention the day before surgery and any further investigations to be undertaken – ensuring patients are ‘good to go’. This approach reinforces the ‘golden patient’ – usually a patient with a fractured neck of femur who is fit and ready and to proceed to surgery the next day

» Trauma co-ordinators in post Monday to Friday 08:00–18:00hrs (August 2018). This enables the trauma cases to be actively managed and the best use made of all theatre time available including other theatre lists where cases are cancelled. This has also improved communication with patients awaiting treatment decisions/ surgical intervention

» Providing additional trauma capacity (Forth Valley has recently appointed two additional Consultant Trauma and Orthopaedic Surgeons commencing September 2019),

» Surgical Frailty Advanced Nurse Practitioner appointed in August 2019. This post will work alongside orthopaedic consultant and orthogeriatric speciality doctors to ensure comprehensive geriatric assessment completed and that patients/relatives are fully informed of all options for care.

» Dedicated Trauma Room for receiving team;

» Senior trainee/ Specialty Doctor taking trauma calls allowing improved communication between patients in the ED/ trauma co-ordinator and consultant;

» Focussed improvement work on length of stay with the use of rehabilitation support workers increasing patient contact with Occupational Therapy, supporting active goal setting for patients, and increasing the involvement of families around expectations and discharge planning. This work is supported by the ‘My Hip Fracture’ folder for patients (giving information, exercises and lifestyle advice post hip fracture)

NHS Grampian

SHFA Standard 2, ED ‘Big Six’ (*ARI 0.9%, Dr Gray’s Hospital 45.4%*)

There has been discussions with the clinicians in ED and an updated patient assessment form was introduced at the end of March. We see an improvement already in the information recorded for each patient

Over the past 6 months Dr Grays Hospital performance in standard 2: the ‘Big Six’ assessments has improved through awareness of staff using a Proforma, IV fluids are given to all patients, 4 AT and pressure area care are also carried out. Improvement work: A&E introduced Proforma, and improved compliance. (Previously recognised IV fluids, Pressure area and 4AT assessments had poor compliance.)
SHFA Standard 3, Inpatient bundle of care *(ARI 35%, Dr Gray’s Hospital 26.8%)*

To improve the recording of nutritional scores, the unit has asked to purchase Marsden Patient Transfer scales which will enable the accurate recording of weight and height at point of admission. Senior Charge Nurses to identify ward “champions”.

The appointment of a dynamic senior charge nurse has increased awareness of the inpatient bundle within a 24 hour period of admission. There has been the introduction of a “Pat Slide” with integrated scales which is increasing compliance with the nutritional assessment element. Improvement work: achieved through education and leadership of new senior charge nurse within Orthopaedic ward.

SHA Standard 7, Comprehensive Geriatric Assessment (CGA) *(Dr Gray’s 26.8%)*

Rationale – due to sickness and depleted resource in the Geriatric team results were poor. Appointment of 2 ANP is showing improvements in performance.

During the last 12 months Dr Grays has had a dedicated Acute Care of the Elderly assessment unit (ACE), within the medical ward. This did initially result in improving the Comprehensive Geriatric Assessments being completed within the 3 days of admission, this however was person dependent and compliance was significantly reduced due to staff sickness. The subsequent appointment of 2 Advanced Nurse Practitioners will support improvement in this area.

SHFA Standard 10, Bone health assessment *(Dr Gray’s 45.4%)*

At Dr Gray’s Hospital: rationale – bone protection assessments currently only carried out by the Geriatrician team, Local exploration under way to develop bone health assessment further at Dr Grays.

SHFA Standard 11, Discharge back to original place of residence within 30 days of admission *(ARI 47.3%)*

Currently in NHS Grampian, there is a lack of support within the community to help support patients in their own homes. Rehabilitation beds are used to help the patient progress back to place of origin. NHS Grampian has access to rehabilitation beds in rural areas nearer the patients’ homes. We have no influence or control over community support and resources and therefore have no option other than to direct patients into rehabilitation facilities to allow patient flow though the Trauma Unit. We believe rehabilitation is a positive step for recovering patients and should not be seen as negative as is suggested in the report, as the data from our centre shows that we have one of the lowest readmission rates (4th in Scotland).

Further feedback from Dr Gray’s Hospital – over the last year we have established the development of an MSK monthly meeting with a MDT team. We have developed a monthly newsletter to share the progress of the audit and our compliance. The local Audit Co-ordination continues to be completed by a band 5 staff nurse 7.5 hours a week. In the absence of specialist resource focusing upon Bone health (Osteoporosis / Hemi-arthroplasty Specialist nurse) reliance is on the Geriatrician team to support this activity within existing resource.
NHS Greater Glasgow & Clyde

SHFA Standard 2, ED ‘Big Six’ (GRI 48.1%, QEUH 7.6% and IRH 38.1%)

The RAH has demonstrated high levels of compliance with Standard 2 since 2016. The other three NHS GGC sites have improved from a low baseline in 2017 with GRI reporting 1%, QEUH reporting 0% and IRH at 4.1%. This improvement has occurred within a context of continuing increase in Emergency Admissions across all our ED departments. For the QEUH, this includes increasing volumes of major trauma in advance of the formal designation as the Major Trauma Centre for the West of Scotland.

The QUEH has the most significant challenge with particular difficulties with respect to Delirium Scoring, Pressure area inspection and IV Fluid commencement. At the GRI, attention is focused on Delirium Scoring and Pressure area inspection. The IRH have more recently experienced a dip with Delirium Scoring and IV Fluids.

Actions to address improvement vary across sites but include:

» Strengthening engagement at integrated quality improvement groups to ensure broader professional involvement;
» Redesign of documentation to improve and streamline appropriate recording of data;
» Education for nursing staff in the use of 4AT delirium scoring tools;
» Targeted use of Trauma Advanced Nurse Practitioners to support ED staff when patients are in ED department;
» Support/promotion of tissue viability assessments and care plans to address risk of pressure damage;
» Trolleys with repose mattresses identified for hip fracture patients within ED department; and
» The QEUH and IRH are prioritising development of reliable procedure to ensure IV fluid administration commences and is documented (QEUH performance in February was 74%).

Action plans are in place for each GGC site and early indications during the first 3 months of 2019 show a continued upwards improvement for the GRI (55%) and QEUH (17%). Impact of improvement work at the IRH is not yet evident (31%).

SHFA Standard 8, Mobilisation rates by end of first day after surgery (IRH 47.9%)

Across NHS GGC, compliance with Standard 8 has been good, above the Scottish average over recent years with the exception of the IRH. The reported figure for 2018 is consistent with previous years. A particular difficulty for the IRH is the lack of 7 day service within a context of lower patient numbers. Audit has shown many of the patients aren’t mobilising due to medical reasons and this is going to be looked into in more detail but no specific trends or problems found with audit. MDT meetings are in place with a focus on data and quality improvement. More broadly, successful improvement work has been conducted on early mobilisation on the elective pathway and the next step is to extend the learning to Trauma pathways.
**NHS Highland**

NHS Highland is committed to providing exemplar care to Hip # patients. The whole Multi-disciplinary Team who are involved in the care of Hip # patients meet regularly to review Hip # data and to identify areas for potential improvement.

**Standard 2**

Completion of the Big Six assessments within ED is an area where we have identified a need for improvement and focus.

Analgesia is administered/ offered, a SEWS score is completed, and bloods are taken within ED routinely and consistently.

Although there has been an improvement in performance related to the commencement of IV fluids, performance is variable. Delirium screening and pressure area inspection within ED are two areas where improvement is needed.

To improve this position, all ED staff have been asked to fully document that these aspects of care have been completed.

Over the coming months, improvements to both the ED staffing profile and compliment are planned which will help with the active completion of the Big Six assessments.

Key to providing continuity during both day time and out of hours are the Emergency Practitioner and Specialty Doctor roles. Both staff groups are being trained to provide nerve blocks for Hip # patients.

**Standard 6**

As a department we have always had a high level of uncemented hemiarthroplasty use when compared to the rest of Scotland. This practice has been reviewed via formal audits on a number of occasions. We do not have a high failure or high revision rate for these implants. Our outcome figures are as good as or better than most other centres across Scotland and in fact we were the first recipients of the Golden Hip Award last year (recognition of high quality hip fracture patient care).

Our patients are well looked after throughout their journey through the hospital and unlike in many units, their surgery is undertaken either by a consultant or by a trainee being assisted by a consultant. There are virtually no procedures undertaken by unsupervised trainees. I think that this is a key point in the success of our operative practice.

While it would be straightforward to change to using cemented implants, this would have potentially negative consequences in terms of increasing the number of perioperative deaths due to adverse reactions to bone cement.
NHS Lanarkshire

The Trauma and Orthopaedic service within NHS Lanarkshire continues through a process of service redesign and quality improvement initiatives to try and improve the outcomes for our patients. The SHFA standards highlighted through the 2018 report remain a focus of monthly Hip Fracture Audit review meetings as well as forming the measures of success as part of NHS Lanarkshire’s T&O redesign programme. These Multi Disciplinary Team meetings are supported by our MSk audit nurses and are run at both University Hospital Hairmyres (UHH) and University Hospital Wishaw (UHW). In addition, a monthly service review meeting, chaired by the Director of Acute Services, is held, where up to date audit data is presented. This focus saw UHW awarded the most improved site in Scotland at last year’s Hip Fracture audit meeting.

NHS Lanarkshire recognises the requirement for ongoing quality improvement and has a number of initiatives in place to deliver improvements.

**SHFA Standard 2, ED ‘Big Six’** *(UHH 34.2% and UHW 15.4%)*

A revised integrated care pathway documentation is being trialled to standardise process across all 3 Emergency Departments (ED) in Lanarkshire.

Alongside this a pan Lanarkshire Neck of Femur Fracture document has been completed. Whilst ICP documentation has previously been in place at UHH this has not been the case on the other sites. As part of the T&O redesign process and the move to a single inpatient Trauma site at UHW the Board has looked to implement new models of care supported by Trauma Liaison nurses as well as Advanced Practice (AP) roles within the service. This will provide additional resources to support the ED to ensure that patients receive the “Big 6” interventions.

**SHFA Standard 3, Inpatient bundle of care** *(UHH 37.3%)*

UHH has already seen considerable improvements in performance against standard 3 since 2018. The last 3 audit cycles have seen performance improve from 37.3% in 2018 to 64.9%. This has been driven through ward education sessions, delivered by the MSk audit nurse, improved documentation and a focus on recording interventions as highlighted through the monthly Hip Fracture audit meetings on the site.

**SHFA Standard 8, Mobilisation rates by end of first day after surgery** *(UHH 47.3%)*

Following investment from the Scottish Government the Board has continued funding of 7 day Physiotherapy and Occupational Therapy at UHW. This has seen improvements against standard 8. The move to UHW being a single site for Orthopaedic Trauma in Lanarkshire will see a reduction in variation that currently exists between UHH and UHW. In the short term, work is ongoing between therapy and nursing teams to ensure all staff are supported to enable early mobilisation of patients. This will remain a focus at UHH ahead of the implementation of the next phase of the Trauma and Orthopaedic redesign.

The development of a pan Lanarkshire Orthopaedic service has allowed for learning between sites and improvements to be made. The department will appoint a clinical lead to specifically focus
on further improvement against the SHFA standards. The implementation of the next phase of the redesign and the move to a single trauma site, with revised pathways and staffing models will also support ongoing improvement against the standards.

**NHS Lothian**

**SHFA Standard 2, ED ‘Big Six’ (10.8%)**

We have undertaken a number of initiatives to improve with compliance on the ‘Big 6’, but the data is clear in that there is further work to do. We have developed a new/hip fracture template on TRAK Care (our electronic patient record system) to support staff in completing the ‘Big 6’ in the ED. It has been agreed between the ED and Orthopaedics services that patients with hip fracture will not be accepted by orthopaedics until the ‘Big 6’ are complete. Run charts with progress in compliance with the ‘Big 6’ will be displayed in the ED Control room and Orthopaedics QI wall.

**SHFA Standard 9, Occupational Therapy assessment (53%)**

Our access to Occupational Therapists (OT) has improved significantly with pump primed funding from the Scottish Government for two additional band 6 OTs. “The audit cycle preceding these posts showed that an average of 46% of patients were being assessed by an OT within 3 days. 2019 data shows that 90% of patients are now being assessed within 3 days. OTs are now anticipating patient pathways, and early collaborative goal setting and discharge planning are being incorporated into initial assessments.

**NHS Tayside** (*NB: no commentary provided about standards 2 and 11 as requested in original letter*)

**SHFA Standard 2, ED ‘Big Six’ (Ninewells 0.4% and PRI 1.9%)**

No commentary provided.

**SHFA Standard 3, Inpatient bundle of care (PRI 55.6%)**

In Perth Royal Infirmary patients with hip fracture were previously admitted to ward 7. During the course of last year (2018) due to changes to ward configuration to offset staff reorganisation we have combined medicine for the elderly ward and trauma hip fracture ward with integrated medical and orthopaedic care for these patients as a part of future reorganisation of services. Hip fracture patients are now being admitted to Ward 1 at Perth Royal Infirmary.

This also coincided with foundation doctors changing periods during 2018. There were several nursing shortages and several staff members were reorganised including newly qualified nursing practitioners. These included the teams in Ward 7 and in Ward 1.

There were significant staff resilience issues at various levels at medical Consultant level and nursing level. In addition to this due to bed capacity issues, there were several trauma diverts from Perth Royal Infirmary to Ninewells Hospital during which the emphasis was on transfer from PRI A&E to NW to get hip fracture surgery.
Majority of the patients were at PRI though sometimes full documentation did not take place during transfer of patients to Ninewells Hospital. Part of it is explained by having two different documentations at 2 sites, though several areas of omission were necessarily because of that and they due to omission and deviation from appropriate assessment.

There was also absence of one of the senior educational supervisor several times during the year 2018 and also a senior surgeon retiring and returning with some time off meant other educational supervisors to FY2 doctors were dealing with additional FY2s for certain periods. As FY2 doctors were responsible for medical components of inpatient bundle of care documentation, due to 4 months attachment and lower number of patient in PRI a duration of non-documentation contributed to data being missed and moving to outlier status.

Action points:
- **FY2 induction:** All FY2s are already emphasised about the importance of documenting the medical components of inpatient bundles of care. Care Group director spoke to current FY2s and this will be part of their induction for new FY2 doctors in August 2019.

- **Uniform admission notes across all sites:** All hip fracture patients to have single admission document to streamline the data collection.

- **Emphasis to nursing staff:** Senior Nurse of the group and Charge nurses to emphasise the importance of the assessments to all ward staff nurses and to be included as part of induction to newly qualified and joined nurses.

- **Educational supervision:** We will aim to manage educational supervision distribution appropriately and new FY2 members using this opportunity with quality improvement audits with support of MSK audit team at PRI. We had a meeting with Deanery with regards to changes to Fy2 working in PRI and a robust induction in July for upcoming Foundation doctors in August 2019.

We have taken the feedback constructively and are making every effort to improve upon our performance.

**SHFA Standard 11, Discharge back to original place of residence within 30 days of admission (PRI 55.2%)**

No commentary provided.

**NHS Western Isles**

**SHFA Standard 2, ED ‘Big Six’ (36.8%)**

Although we only managed to do all six in 37% of cases, we managed to do 4–6 in 95% of cases. We have identified the areas where the ED ‘big 6’ bundle is not completed and will review our current process to highlight areas where improvements are required.
SHFA Standard 3, Inpatient bundle of care (8%)

Regarding the inpatient bundle of care there have been a few instances of the Waterlow, falls assessment or MUST being incomplete but generally these are all done. We don’t manage all four often but in 72% of cases we managed three. We are not meeting the standard as there is a requirement for the 4AT to be repeated within 24 hours of admission and our current process and documentation does not prompt or facilitate this. We plan to resolve this by putting mechanisms in place for the 4AT to be repeated on the ward.

SHFA Standard 4, Patients to theatre within 36 hours of admission (55.1%)

There are several factors contributing to this:
1. Patient fitness for theatre due to ongoing medical issues; and
2. Theatre capacity does not allow us to operate within 36 hours in all cases. Recent closure of the decontamination unit, an increase in theatre demand across all specialties, and TTG all affect our ability to meet this standard.

SHFA Standard 7, Comprehensive Geriatric Assessment (CGA) (20.8%)

We recognise we have a gap in this respect and continue to work on ways to address this. We are currently looking at the possibility of a nurse led frailty service.

SHFA Standard 9, Occupational Therapy assessment (51%)

Looking at IT solutions to improve this outcome. There had been some initial glitches with the system but are now confident this will improve.

SHFA Standard 10, Bone health assessment (22%)

The Bone Health Assessments should be addressed by the new FLS post which is currently out to advert.
Further Information

Further Information can be found on the ISD website.

The next release of this publication will be August 2020.

Rate this publication

Please provide feedback on this publication to help us improve our services.