

The Scottish Hip Fracture Audit

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Chairman Scottish Hip Fracture Audit



#ScotHipAudit



www.shfa.scot.nhs.uk



























Hip Fractures: A Scottish perspective

- 22 cases per day.
- 140 000 NHS bed days per year.
- £200 million care cost per annum.
- More bed days than MI/CVA combined.
- >85% of total cost of all fragility fractures.







Why audit hip fractures?

 \bigcirc

The fragility fracture career



Adapted from Kanis JA, Johnell O; 1999

Age

Heterogenous patient group



The Orthopaedic Surgeon

Strong as an Ox and twice as clever...



"...straining a brain which Nature had never intended for hard exercise ..."

PG Wodehouse, 1935

Multi-disciplinary approach to a multi-disciplinary condition



Hip Fracture – "A Tracer Condition for Multi-disciplinary Care" JD Hutchison

GP A & E SALT **TSSU Paramedics Occupational therapists Anaesthetics Nursing Staff Acute Medicine** Porters Care of the elderly Radiographers Family/Carers **Social services Physiotherapists Theatre staff** Orthopaedic surgeon



Edinburgh Royal Infirmary hospital's elderly care 'still poor'

C 11 April 2013 Edinburgh, Fife & East Scotland

The Royal Infirmary of Edinburgh has been told it must do more to improve the care of older people.

A second inspection of the hospital has been carried out following a severely critical inspection in August last year.

Healthcare Improvement Scotland said most patients were still not being assessed for dementia, pressure ulcers, nutrition and hydration.



Inspectors noted improvements at the Royal Infirmary of Edinburgh but called for further progress

The wards were also not appropriate for people with dementia.



Geriatric day unit

Hospital Mortality

- What is 1 year mortality of a hip fracture patient?
 26%
- What is the 1 year mortality of an 81 year old female?
 21%
- What is the 1 year mortality rate of a patient admitted to hospital in Scotland as an emergency?
 - 33%





Scottish population 1951







Scottish population 1991







Scottish population 2031









Incidence Rate of Hip Fracture by Gender and Age in Scotland 1999 – 2016

Figure 2: Gender specific incidence rates of hip fracture (per 100,000) grouped according to age between 1999 and 2016.

Total Annual Number of Hip Fractures in Scotland 1999 – 2016



Figure 1: The total annual number of hip fractures from 1999 to 2016, including gender classification.

Historic and Projected Total Annual Number of Hip Fractures in Scotland 1999 – 2035 (Static Incidence Rate Estimate)



Hospital Bed Requirements

- By 2031 number of bed days will increase by 80%.
- Requires an additional 475 hospital beds in Scotland.
- Approximately 5000 extra beds across the UK.
- Cost increase from £2 billion to £5-6 billion.





Scottish Hip Fracture Audit - A Quick History -

- Started back in 1993
- Based on Swedish Rikshöft study.
- Included all patients who sustained a hip fracture aged 50 years and older.
- Initially involved 4 hospitals.
- By 2006 was a national centrally funded audit.



NHS

SCOTLAND

www.show.scot.nhs.uk/shfa Information & Statistics Division Scottish Intercollegiate Guidelines Network

56

Prevention and Management of Hip Fracture in Older People A national clinical guideline



January 2002



Falls and Fragility Fracture Audit Programme (FFFAP)

National Hip Fracture Database (NHFD) **annual report 2015**



NICE National Institute for Health and Care Excellence

NICE guideline

Hip fracture: management

Clinical guideline Published: 22 June 2011 nice.org.uk/guidance/cg124



Scottish Hip Fracture Audit Report 2008

Information Services Division (ISD)

www.shfa.scot.nhs.uk

NHS

National Services Scotland





Audit of Care Pathways for Hip Fracture Patients in Scotland December 2012 to March 2013





Audit of Care Pathways for Hip Fracture Patients in Scotland

December 2012 to March 2013

A Report from the Musculoskeletal Audit on behalf of the Scottish Government

The information in this report is intended to be used for improvement purposes. The information has been collected by local MSK Audit co-ordinators based in each hospital. These statistics have not been through ISD's official statistics quality assurance process but have been subject to the MSK Audit's own quality assurance process, and were pre-circulated to each hospital for comments on accuracy.

We report on a four-month 'snapshot' audit commissioned by the Scottish Orthopaedic Service Development Group (SOSDG) on behalf of the Scottish Government that collected data on the management of hip fracture patients from **all Scottish operating hospitals** from 1st December 2012 to 21st March 2013.



Contents lists available at ScienceDirect

Injury

journal homepage: www.elsevier.com/locate/injury

National audits of hip fractures: Are yearly audits required?

CrossMark

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ABSTRACT

Introduction: Hip fractures are a significant cause of morbidity and mortality to the increasing elderly population. The Scottish Hip Fracture Audit started in 1993 with national audits from 2002. It was a national prospective audit reporting on clinical standards in hip fracture care and produced an annual report. Due to national funding changes the continual audit was discontinued in 2008. In 2013, the MSK Audit Group published a "snapshot" into a 4 month period of hip fracture care in Scotland. Our purpose was to identify whether there had been an initial improvement in hip fracture care and whether this improvement was sustained with the discontinuation of the annual audit.

Methods: The reported outcomes from the annual Scottish Hip Fracture Audit from 2003 to 2008 were compared to the latest MSK Hip Fracture Audit published in 2013. Some data is available from the 2014 MSK Hip Fracture Audit and this was also used for comparison purposes. Local audit co-ordinators at each participating site collected a data-set for all patients admitted with a hip fracture. The case mix variables and management variables were compared for the reported years.

Results: The continual audit demonstrated an improvement in the percentage of patients discharged from accident and emergency in 4 h (80.5% 2003 vs. 96% 2008) which was not maintained 5 years later. An improvement in the percentage of patients having surgery within 48 h of admission (89.9–98.4%) was

Time in Emergency Department



Fig. 5. Accident and emergency stay.





Time to Surgery



Scotland



30/120 Day Mortality


Unexplained Variation in Hip # Care - ED Analgesia -



Percentage of patients

Use of Cement



Cognition Testing



We do many things well...

...not everywhere...

...and not all of the time





Poor Quality Care Costs Money!!!!!



How do we change established poor practice and eliminate unnecessary variation?

Barriers to change in the NHS





Resource barriers

Behavioral barriers







Home \rightarrow Connecting doctors \rightarrow The Secret Doctor \rightarrow CPR good, ECT bad - two undeserved reputations



The Secret Doctor

CPR good, ECT bad - two undeserved reputations

'We think your mother could benefit from electroconvulsive therapy,' the consultant said. A look of undisguised horror appeared on our patient's daughter's face.





















"Humans are allergic to change. They love to say, 'We've always done it this way.' I try to fight that. That's why I have a clock on my wall that runs counter-clockwise."

- Grace Murray Hopper

Re-introduction of SHFA

MsK Orthopaedic National Quality Improvement Pathways



DEMAND & CAPACITY PLANNING MANAGEMENT

- supporting strategic & operational decisions

Multi-disciplinary Steering Group

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Evidence based medicine approach.....

Evidence based medicine approach.....

Clinical Judgment Relevant Scientific Evidence

Patients' Values and Preferences

EBM

Mortality after hip fracture.



Marginal Gains Principle

Sir Dave Brailsford –

"The whole principle came from the idea that if you broke down everything you could think of that goes into riding a bike, and then improved it by 1%, you will get a significant increase when you put them all together"



Marginal Gains



Is the Marginal Gains Principle Clinically Relevant?



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Acute Adult

SCOTTISH

PATIENT

SAFETY

PROGRAMME

Improving reliable care delivery, communication and care planning.

Reducing harm and morality in hospitals.

HAI

Provide a coordinated improvement resource to NHS Scotland around HAI

Establishing reliable systems and processes around the prevention of HAI

Maternity and Children

Improving outcomes for babies, children and their mothers.

In creasing women's satisfaction of their experience of care.

Medicines

Taking a whole system approach the the safer use of medicines.

Optimising medication reconciliation and reducing harm from high risk medicines.

Mental Health

Improving risk assessment and safety planning.

Reducing harm from restraint ans seclusion.

Primary Care

Improving safety in the community and across the interface.

Reducing harm from high risk medicines.

30 Day Mortality - NHFD



2003 2004 2005 2006 2007 2008 2009 2010 2011

Notes: Y axis is on log scale, with labels on natural scale (%). Time is measured in 3-month intervals, with the final quarter of 2007 marking the end of the first time period (2003–2007) and the start of the second (2007–2011).

Quality of Care in Hip Fracture Patients: The Relationship Between Adherence to National Standards and Improved Outcomes

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JBJS: May 2, 2018 - Volume 100 - Issue 9 - p 751-757 doi: 10.2106/JBJS.17.00884 Scientific Articles



Abstract

Author Information

Background: Optimizing the perioperative care of patients with a hip fracture is a key health-care priority. We aimed to determine whether adherence to the Scottish Standards of Care for Hip Fracture Patients (SSCHFP) was associated with improved patient outcomes.

Methods: In this retrospective cohort study of prospectively collected data from the Scottish National Hip Fracture Audit, we assessed adherence to the SSCHFP in 21 Scottish hospitals over a 9-month period in 2014 and examined the effect of the guidelines on 30 and 120-day mortality, length of hospital stay, and discharge destination.

Results: A total of 1,162 patients who were \geq 50 years old and admitted with a hip fracture were included. There was a significant association between low adherence to the SSCHFP and increased mortality at 30 and 120 days (odds ratio [OR], 3.58 [95% confidence interval (CI), 1.75 to 7.32; p < 0.001] and 2.01 [95% CI, 1.28 to 3.12; p = 0.003], respectively). Low adherence was associated with a reduced likelihood of a short length of stay (OR, 0.58; 95% CI, 0.42 to 0.78; p < 0.0001), but increased odds of discharge to a high-care setting (OR, 1.63; 95% CI, 1.12 to 2.36; p = 0.01). Early physiotherapy input and occupational therapy input were associated with a reduced likelihood of discharge to a high-care setting (OR, 0.64 [95% CI, 0.44 to 0.98; p = 0.04] and 0.34 [95% CI, 0.23 to 0.48; p < 0.001], respectively).

Annual Report



Realtime feedback











FRACTURE CONFERENCE

FRIDAY 24[™] AUGUST 2018 **RADISSON BLU, GLASGOW G2 8DL**





The RAH staff have picked up their second Golden Hip award



By Alison Rennie 18:22, 5 SEP 2018 UPDATED 18:25, 5 SEP 2018







Complication Reporting/Outlier Identification



Website

The Scottish Hip Fracture Audit



Home

About the audit Reports Quality Improvement Access to data Education

For Patients

Contacts

SHFA Latest News

Spotlight newsletter

Hip Fracture Care Pathway Report 2017 Published 22 Aug 2017



Hip fracture.

Hip fracture is the most common, serious orthopaedic injury to affect the elderly, with more than 6,000 patients admitted to hospital in Scotland each year. The burden of hip fracture in Scotland is likely to increase significantly over the coming decade as a consequence of population demographic changes. It is therefore essential that we manage this injury as effectively and efficiently as possible, primarily for the benefit of patients, but also for the optimum use of NHS resources. Hip fracture represents an effective 'tracer' condition as the management of this injury often requires a complex journey of clinical and social care involving many different disciplinary teams and community based services. As such, if we improve the quality of care for hip fracture patients, then we can expect to improve the care provided to other fragility fracture patients.









Quarterly Spotlight



IMPLEMENTATION

Louise McGaw, Deputy Charge Nurse from Ward 2C, University Hospital Crosshouse shares her experience of how her team have worked together to improve achievement of this standard. They have shown sustained improvement over the past 6 months and have increased the numbers of hip fracture patients who are given oral fluids prior to surgery from 40% in December 2016 to an impressive 100% in June 2017.

'In order to improve fluid fasting times for patients who have sustained a hip fracture it was crucial for us to identify the areas that required improvement.

Two main areas that were identified were:

- Audit nurse had difficulty finding documentation that reported final fasting intake and time.
- Communication within multidisciplinary team members regarding theatre times.

To improve these areas we firstly devised a fasting fluid chart that is positioned at the start of the patients nursing profile which clearly identifies the time fluids were last taken and amount. This provided easy accessibility for the audit nurse to retrieve the information that was required.

Ward shift leaders played a pivotal role on the ward round by asking anaesthetists and consultants the patients' position on the theatre list to confirm if additional clear fluids could be offered and until what time. The shift leader then had the responsibility to communicate this information to all staff members to encourage fluid intake up to two hours prior to theatre as recommendation by the Hip Fracture Care Pathway Report (2016). Following additional fluid intake it was imperative the fluid chart was further updated. Finally, on occasions where patients were cancelled for theatre a new fasting fluid chart was commenced over the next fasting period to promote accuracy with fluid fasting times."

Resources from other hospitals as well as a copy of the fluid checklist from NHS Ayrshire and Arran are available for use on the SHFA website The Scottish Hip Fracture Audit.

WHERE CAN I FIND OUT MORE?

http://www.shfa.scot.nhs.uk/ docs/20161109_SSC for Hip Fracture Patients.pdf.

Inspirational campaign from Nottingham University Hospital on how they tackled changing people's perceptions of fasting prior to surgery.

- http://patientexperiencenetwork.org/case-studies/nottingham-university-hospitalsthink-drink-project/.
- https://youtu.be/mn4ynZtAaiA.





Patient Information



You've broken your hip – this happens when the thigh bone at your hip bone breaks



Why did it happen to me?

- Just over one in 20 people over the age of 65 will suffer from a hip fracture.
- Hip fractures are very common and are usually due to a fall.
- A condition called 'osteoporosis' can weaken bones, meaning that they break more easily.
- It's more likely to happen to women as they are more likely to have osteoporosis.

What happens now?

- Pain often causes people the most worry. You will be given painkillers by the ambulance staff and then when you get to hospital. The pain usually improves after the bone is repaired.
- It's likely that you will be offered an operation to repair the fracture. However, you can decide if this is the best option for you.
- You can discuss your treatment with your consultant who will help you to understand the options available.
- If you decide to have an operation, it should be carried out within 36 hours of your admission to hospital.

Can anything go wrong?

- It's important to know that things can go wrong sometimes. However, the risks are low and usually depend on the state of your health when you are admitted to hospital.
- It's very common for people to become confused. This is called 'delirium' and can be caused by some medications, infection or the shock to your body from the injury. This is usually a temporary condition which will clear up as you recover.
- Sometimes, people can experience infection, blood loss, clots in the leg or ongoing pain.





Scotland 'leading the world' in treatment of hip fractures, finds Aberdeen University study

Helen McArdle Search (McardleHT) Health Correspondent



2 comments

However.....

Needless deaths from broken hips are blamed on poor care



Catherine Calderwood, chief medical officer for Scotland, said a 2017 audit showed improvements to care for those with hip fractures EMILY MACINNES FOR THE TIMES

Patients with broken hips are dying unnecessarily in hospitals because staff are not delivering the right care.

"Ongoing <u>unexplained</u> and

unacceptable variation in the

quality of care provided to hip

fracture patients in Scotland"





Cumulative achievement of standards












Are we making a difference?



SHFA Report 2017

• Reports on <u>6,669</u> hip fractures between January and December 2017.

 Represents <u>93%</u> of all patients admitted during this time period.

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









We have again seen an increase in the percentage of patients waiting over 4 hours in ED (10%), a 2% increase from 2016 (8%). There also continues to be a slight increase of 1% of those patients waiting from 2–4 hours in ED (75% in 2016, 76% in 2017).

Hip Fracture "Fast-track" Protocol

- Hip fracture identified by SAS if possible.
- Transfer to specialist area of ED.
- Hip fracture ward informed and bed made ready on <u>ED arrival</u>.
- Rapid medical assessment and radiographs.
- Fascia iliaca block.
- "Big 6" pre ward transfer interventions.
- Transfer to hip fracture ward within 2-4 hours.

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

- 1. Provision of pain relief (FIB)
- 2. Screening for delirium
- 3. Early Warning Score (EWS) system
- 4. Full bloods investigation and ECG
- 5. Intravenous fluid therapy
- 6. Pressure area care





The "Big 6"

Fig. 2.1 'Big Six' ED interventions/treatments











Fascia Iliaca Blocks





Every patient with a hip fracture should receive the 'inpatient bundle of care' within 24 hours of admission.



Patients must undergo surgical repair of their hip fracture within 36 hours of admission.

- Every additional pre-operative day adds 2-3 days extra length of stay.
- Increases mortality by 20-30% for every 24 hour delay.





Patients must undergo surgical repair of their hip fracture within 36 hours of admission.



Covernment

Services Scotland



Fig. 4.2 Reasons for theatre delay if more than 36 hours







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

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-exisiting ambulatory status should be a consideration when selecting the type of implant.







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

Fig. 7.1 Hemi-arthroplasty—use of cement







Type of Surgery



- THR 8% of all hip fractures in England vs. 6% in Scotland.
- IM nail increasing in use against NICE and clinical evidence.

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







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.



National Services Scotland

Time until physiotherapy assessment



All patients with a hip fracture should have an Occupation al Therapy (OT) assessment by the end of day three post-operatively.

T me from surgery until seen by OT Fig. 10.1 100% Percentage of patients 80% 60% 40% 20% 0% within 3 days of operation not seen within 3 days not known





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









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.







Models of care for the delivery of secondary fracture prevention after hip fracture: a health service cost, clinical outcomes and costeffectiveness study within a region of England

Health Services and Delivery Research, No. 4.28

Andrew Judge, M Kassim Javaid, José Leal, Samuel Hawley, Sarah Drew, Sally Sheard, Daniel Prieto-Alhambra, Rachael Gooberman-Hill, Janet Lippett, Andrew Farmer, Nigel Arden, Alastair Gray, Michael Goldacre, Antonella Delmestri, and Cyrus Cooper.

- Judge et al. cost for average patient is £15 000.
- £500 £700 per day.
- Hospital stay accounts for 84% of total cost.

Median length of total hospital stay



median +/- 25 and 75 percentiles

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







Discharge Destination



27% use of ortho rehab vs. 71%!

Does the routine use of GORU increase length of stay after hip fracture?





Fig. 2a: Median total hospital stay in relation to % patients discharged to rehab in each hospital

The median total LoS was <u>positively</u> correlated with the percentage of hip fracture patients discharged to rehab (p=0.02).

Fig. 2b: Percentage patients home at 30 days in relation to % patients discharged to rehab in each hospital



The percentage patients who were home 30 days post-admission was <u>negatively</u> correlated with the percentage discharged to rehab (p=0.04).
Length of stay

- Has reduced from 22 to 18 days.
- LoS varies from 14 to 28 days.
- If we reduced length of stay from median (18 days) to the best performing units (14 days) would save approximately 42 000 bed days.
- 115 hospital beds (require 475 extra by 2031).
- Equivalent to £30 million per annum saving.

30 day mortality - 2013



• 9% 30 day mortality in 2013 (range 5-14%).

30 day mortality - 2016

30-day hip fracture patient survival/mortality - July to December 2016



30 day mortality – 2017



Criterion	SHFA 2013	SHFA 2017	NHFD
4 hour ED transfer	80%	90%	40%
Theatre within 36 hours	65%	71 %	70%
Falls assessment	70%	97%	96%
Cognitive assessment	70%	95%	94%
Bone protection assessment	60%	90%	96%
Physiotherapy by day 1	65%	90%	94%
Cemented hemi-arthroplasty	70%	90%	86%
Mobilised by day 1	60%	74%	77%
CoE assessment 72 hours	50%	78%	89%
Nutrition assessment	70%	84%	85%
30 day original residence	50%	60%	67% (4 months
Length of stay (overall)	22 days	18 days	21 days
30 day mortality	9%	7.1%	6.8%

Doing Good

Doesn't

"Just Happen"



Summary

- LoS reduced from 22 days to 18 days (18%).
- 90 000 bed days saved over last 3 years.
- £45 million cost saving.
- Mortality fallen by 22%.
- 150 lives per year saved.
- Over 80% seen by CoE within 72 hours.

However.....

Needless deaths from broken hips are blamed on poor care



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