

Delivering Healthy Ambitions Better for Less



Overview.

Looking after hip fracture patients well is a lot cheaper than looking after them badly. Better quality care can be delivered at reduced cost with patients and clinicians seeing the benefits.

Why fractured neck of femur?

Over 30,000 patients present to hospitals in Yorkshire and the Humber with fragility fractures each year, with medical and social care costs – most of which relate to hip fracture care – at around £200m or £14m per PCT.

Fractured neck of femur is the most serious consequence of falls in older people with a mortality rate of 10% at one month after a fall, 20% at four months and 30% at one year.

The care and rehabilitation of patients with hip fracture is the central challenge for UK trauma services, but the quality and cost effectiveness of such care varies considerably across the region.

One marker of the quality of care patients receive is the total length of NHS care. The average length of superspell (total time in NHS care, including community care) is 28 days although this varies considerably between Trusts from 17 to 40 days.

These patients are among the most frail to be admitted to hospital, and their outcomes depend critically on how effectively their care pathway is managed. Avoidable delay, incomplete assessment and lack of attention to important details—such as co-morbidities, fluid balance and nutritional status, as well as the underlying cause(s) of the fall and subsequent management of their osteoporotic risk—will result in poorer outcomes. Pre-operative delays increase mortality and, in those who survive, prolongs post-operative stay.

What is the picture in Y&H?

There were around 5,600 fractured necks of femur across Yorkshire and the Humber in 2007/8. This costs each PCT an estimated £4m, including £2.5m in emergency admissions alone. While identifying patients at risk and preventing falls will be a key strategy for PCTs, providing high quality and appropriate hospital care when needed can significantly improve outcomes and patient experience at the same time as reducing costs.

There are currently large variations in the average length of stay and 28 day re-admission rates for fractured neck of femur in providers across our region. Addressing these variations is key to providing better care for less.

Average length of stay

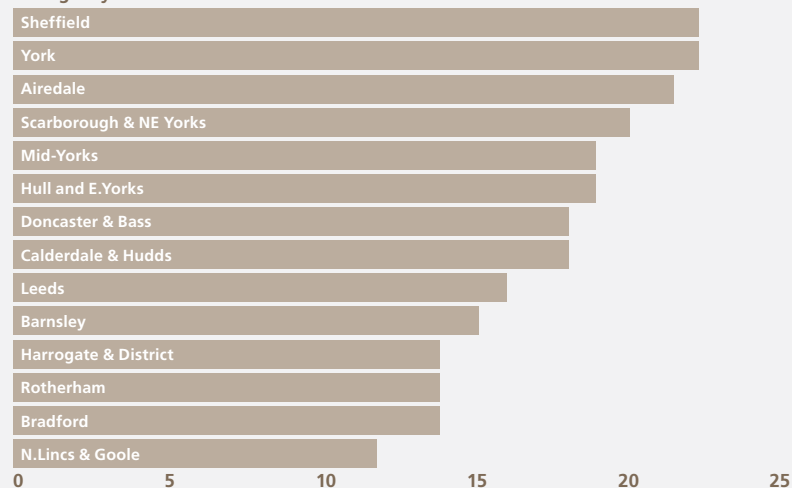
Average length of stay for fractured neck of femur varies from 12 to 23 days across providers in Yorkshire and the Humber (see Fig 1).

The top 10% of providers in England achieve an average length of stay of 15 days or less. Reducing the average length of stay for fractured neck of femur by an average of 3 days would save Yorkshire and the Humber approximately £2.7m.

Emergency re-admissions

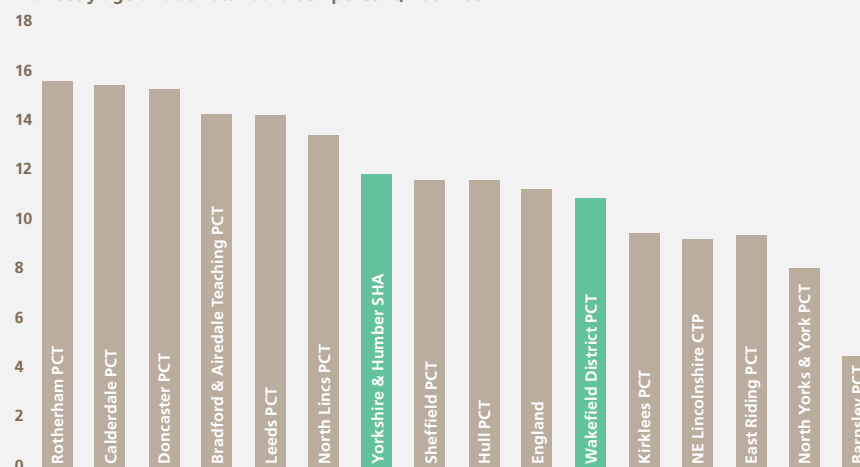
Around 12% of patients discharged from NHS hospitals following emergency admission with a fractured neck of femur are readmitted as an emergency within 28 days, which costs the region around £1m. There is a 3-fold variation in re-admission rates across PCTs in Yorkshire and the Humber (see Fig 2).

Fig 1
Average Length of Stay (Days) H87–Neck of Femur Fracture with Hip Replacement w/o cc, Emergency Admissions 08-09



source: SHAPE, Hospital Episode Statistics (HES), The NHS Information Centre for Health and Social Care

Fig 2
Emergency re-admissions within 28 days for fractured proximal femur–Indirectly age and sex standardised percent, 2007–08



Source: NCHOD

What is the challenge?

Despite a well established evidence base, best practice care has not been adopted across the region. The cost (both human and financial) of poor care is far more than that of providing best practice care.

Currently there is a significant variation in both practice and outcomes for patients with 'fragility fractures' – only 68% are treated (surgery) in 48hrs of admission – this adds up to 3 days (for each pre-op day) to their overall length of stay.

Care and rehabilitation of patients with hip fracture is the central challenge for trauma services; and those that can provide good care for these patients will cope well with the range of other fragility fractures encountered.

How could we provide better care for less?

The evidence-base for hip fracture care shows that prompt, effective, multidisciplinary management can improve quality and reduce costs.

Best practice care for fractured neck of femur is well defined. The NHS Institute describes the following elements of an effective care pathway:

- A co-ordinated pathway designed to reduce variation in length of stay, reduce mortality and re-admissions
- Appropriate, medically fit patients receive surgery within 24 hours
- Patients are mobilised within 12-18 hours post op and receive therapy input over weekends
- Patients are discharged back to their usual address using a criteria based discharge process
- Health and social care multi agency teams are co-ordinated and integrated across the patient pathway
- The multi disciplinary team works in partnership with an orthogeriatrician
- Secondary prevention, combining bone protection and falls assessment (see the 'Comprehensive Falls Pathway' Better for Less Briefing note, available from www.healthyambitions.co.uk)

The British Orthopaedic Association 'Blue Book' (<http://www.fractures.com/pdf/BOA-BGS-Blue-Book.pdf>) provides an authoritative evidence-based clinical guide for the multi-disciplinary team on best practice in the management of hip fracture.

The standards reflect good practice at key stages of hip fracture. All patients with hip fracture should:

1. Be admitted to an acute orthopaedic ward within 4 hours of presentation
2. Be assessed and cared for with a view to minimising their risk of developing a pressure ulcer
3. If medically fit, have surgery within 48 hours of admission, and during normal working hours

All patients presenting with a fragility fracture should:

4. Be managed on an orthopaedic ward with routine access to acute orthogeriatric medical support from the time of admission
5. Be assessed to determine their need for antiresorptive therapy to prevent future osteoporotic fractures
6. Be offered multidisciplinary assessment and intervention to prevent future falls

Compliance with them would improve the quality and outcomes of care and also reduce its costs. The rationale for them is set out in the Blue Book, and compliance can be continuously monitored by participation in National Hip Fracture database (NHFD). The NHFD enables hospitals to compare care and outcomes against national benchmarks and quality standards.

Patient benefits

Implementing best practice will mean more people will live, with less disability and will retain their independence for longer. Currently approximately half of fractured neck of femur patients who were previously independent become partly dependent, while one-third become totally dependant.

Quality benefits

The benefits of best practice care in fracture neck of femur include reduced mortality, reduced inpatient days, reduction in adverse events and a greater likelihood of recovery and full independence, reducing the requirement for long term care.

Financial benefits

Looking after hip fracture patients well is a lot cheaper than looking after them badly.

A Best Practice Tariff now exists to promote the spread of high quality fractured neck of femur care. From 2010/11 the tariff will be paid in two parts, a base tariff for each HRG and an additional payment for achieving best practice standards.

Length of hospital stay varies considerably between units: in the acute ward averaging between two and three weeks; and with overall hospital stay averaging as much as five weeks. Differences in length of stay largely reflect differences in service structures and provision, such as in early rehabilitation, the availability of downstream beds, and of community rehabilitation services.

Length of stay accounts for the majority of overall hospital costs, which are estimated to be between £5,600 and £12,000 per case. After discharge from hospital, the cost of complex home and institutional care for people who make a poor recovery is very high, with average additional costs for health and social aftercare of £13,000 in the first two years.

Current projections suggest that, in the UK, hip fracture incidence will rise from the current figure of c. 70,000 per year to 91,500 in 2015 and 101,000 in 2020. This indicates that the scale of savings will increase with the prevalence of hip fractures.

This profile of the mortality, morbidity, loss of independence and the resulting clinical and financial impact on health and social services from hip fracture alone emphasises the need for care based on the best available evidence.

What needs to happen?

- Commissioners reflect “blue book” expectations in their contracts and contract monitoring mechanisms
- Commissioners should seek to implement a comprehensive falls care pathway - see Better for Less briefing from www.healthyambitions.co.uk
- Providers need to ensure compliance with the standards described in the blue book.
- Commissioners and providers should utilise the NHS Institute ‘focus on fractured neck of femur’ resource pack and consider using these ideas as a means of improving the care pathway

A local case study - Barnsley Foundation Trust

The trust has established a programme of training for nursing assistants to enable the staff to continue mobilising patients over the weekend when physiotherapy staff are not available. The competences include risk assessment, understanding of patients’ documentation, safety of patients and walking aids, provision of appropriate walking aids, and understanding of mobility re-education.

Implementing a best practice approach to fractured neck of femur, Barnsley Foundation Trust have reduced LOS from 20 to 14 days, equal to 1,650 bed days and £379,500 based excess bed days tariff.

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of femur resources
(includes '8 questions to ask your Trust')
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NHS Y&H, 'Comprehensive Falls Pathway'
Better for Less Briefing
<http://www.healthyambitions.co.uk/BetterForLess/>