NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Hip fracture in adults

Date of Quality Standards Advisory Committee post-consultation meeting:
25 May 2016

2 Introduction

The draft quality standard for hip fracture was made available on the NICE website for a 4-week public consultation period between 5 April and 4 May 2016. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 20 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be put them in place?

3. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any treatment. Please describe any potential cost savings or opportunities for disinvestment.

Stakeholders were also invited to respond to the following statement specific questions:

1. For draft quality statement 2: Do most hip fracture surgeries currently take place under the supervision of senior staff?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- In general, the statements were welcomed as areas where there is the greatest need for improvement.
- Satisfaction with the coverage of the patient pathway.
- Suggestion to expand the scope of this quality standard to cover rehabilitation after discharge.
- Concern about the reduced number of statements.
- Need for consistency between this quality standard, the National Hip Fracture Database and the Best Practice Tariff.
- Suggestion to change the order of the statements.
- Concern that the statements are not easily measurable.
- Suggestion to include the role of the pharmacist in the management of hip fracture.
- A stakeholder highlighted the need for training schemes for anaesthetists who want to specialise in hip fracture care.
- Suggestion to include diagnostic tests for hip fracture.

Consultation comments on data collection

- Possible to collect the data but there may be variation in the local systems across the country.
- Concern that the statements are too diverse to be used as framework for the national clinical audit for hip fracture.

Consultation comments on resource impact

- Difficult to achieve multidisciplinary input across the pathway as it requires management, ownership and governance across more than one organisation.

- Expectation to achieve cost savings from better mobility and reduced length of stay.
- Need for resources for rehabilitation services as availability is variable.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Adults presenting with hip fracture receive prompt pain management that is based on an assessment of their pain.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Suggestion to also cover the post-surgery period.
- Suggestion to remove measures a) and b) as paracetamol is not captured by the National Hip Fracture Database (NHFD).
- Some stakeholders suggested adding a process measure on nerve blocks.
- Suggestion to specify a maximum time between registration and first assessment of pain.
- Suggestion to make the statement more specific in terms of pain assessment, pain management and clinical outcome measurement.
- Suggestion that pharmacists should be involved in pain management.
- Analgesia needs to continue post-operatively to facilitate mobilisation.
- Suggestion to cover the use of pain assessment tools.
- Suggestion to focus the statement on a specific intervention.
- Query on how the assessment and efficacy of analgesia will be measured.

5.2 Draft statement 2

Adults with hip fracture have surgery on the day of, or the day after, admission under the supervision of senior surgeons and anaesthetists.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Stakeholders said this remains a key area for quality improvement.
- Suggestion to add planned trauma list to the statement.
- Suggestion to remove outcome measures b, c, d and e as they are not attributable to the presence of senior surgeons.
- Query on why seniority applies to surgeon and anaesthetist only.
- One stakeholder suggested that competency is more important than seniority.
- Suggestion to use the 36 hour timescale.
- Suggestion to define 'senior' according to the NHFD.
- Need to specify 'post-operative complications'.
- Suggestion to define 'post-operative delirium'.
- Specify if outcome measure e) means discharge directly from hospital or following rehabilitation.
- Need to be specific at what point mortality is to be measured.
- A stakeholder pointed out that post-operative delirium is a post-operative complication.
- Concern that data collection varies in different trusts and suggestion to make anaesthesia data collection via NHFD mandatory.

Consultation question 5

Stakeholders made the following comments in relation to consultation question 5:

- Present at 91.7% of operations according to the NHFD ASAP audit.
- Yes.

5.3 Draft statement 3

Adults with displaced intracapsular hip fracture receive cemented arthroplasty, and those who are assessed as clinically eligible are offered a total hip replacement.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Suggestion to become statement 4.
- Some suggestions to include all types of hip fracture.

- Need clarity regarding the eligibility for the surgery in particular fitness for surgery and anaesthesia.
- Suggestion not to include patients who choose not to have total arthroplasty in the process measures.
- Patients should be counselled on the risk of cement implantation syndrome and suggestion to remove cemented arthroplasty from the statement.
- Concern that uncemented arthroplasties have been excluded from the statement.
- Concern that total hip replacement is not more cost effective than hemi-arthroplasty and it doesn't reduce the re-operation rate.

5.4 Draft statement 4

Adults with hip fracture start daily mobilisation on the day after surgery.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Suggestion that mobilisation can start earlier for some people and change the statement to 'no later than the day after surgery'.
- Suggestion to remove 'contraindications' from the process measure to be compatible with the NHFD.
- Suggestions to replace 'contraindications to physiotherapy' with contraindications to rehabilitation'.
- Suggestion to add 'balance' on what the exercises would entail for patients.
- Need to specify at what point after surgery to assess the person's mobility.
- Need for a comprehensive rehabilitation programme until discharge.
- Suggestion to use the term 'rehabilitation including mobilisation' rather than 'mobilisation' alone.
- A stakeholder pointed out that radiographic imaging may be required prior to mobilisation.
- Suggestion to add a process measure for people who cannot start mobilisation because of pain.

- Suggestion to add a process measure on people assessed by a physiotherapist on the day of or day after surgery.
- A stakeholder suggested that the duration of time over which the number of physiotherapy and occupational therapy hours are needed is not clear.

5.5 Draft statement 5

Adults with hip fracture are offered a formal orthogeriatric-led Hip Fracture Programme when admitted to hospital.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- Suggestion to become statement 1.
- Concern that the statement can be easily met without benefit for the patient.
- Suggestion to reword the statement to state ‘are cared for within’ rather than ‘offered’ to reflect the nature of a HFP.
- There were a number of suggestions for new measures and amendments to existing measures and concerns were raised about aligning them with the NHFD.
- Resource issue regarding geriatrician-led input into post-discharge care in the community.
- Need to specify how much involvement the orthogeriatrician should have.
- Suggestion to define ‘rapid optimisation’.
- Suggestion to extend the statement across the whole care pathway.
- Suggestion to include medication review and involve a specialist pharmacist in bone health in the Hip Fracture Programme.
- Suggestion to replace the term ‘optimisation’ with ‘normalisation’ to avoid unnecessary treatment before surgery.
- Consultant anaesthetists should be involved in the perioperative management of hip fracture.
- Suggestion to include high dependency care for high risk patients.
- Suggestion to include bone assessment for prevention of future fractures.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Bone assessment and secondary prevention.
- Rehabilitation after discharge.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement number	Comments
1	AGILE	Introduction	"This quality standard covers the diagnosis and management of hip fracture from admission in secondary care to final return to the community, in adults (aged 18 years and over)." COMMENT: the scope of this quality standard needs to be expanded to cover effective rehabilitation after discharge. Otherwise it is not going to be effective in achieving its stated goal of contributing to reductions in re-admissions to hospital (as stated on page 2). Consideration and referral for ongoing community based rehabilitation by the acute team, and the subsequent provision of that rehabilitation by the community team, is essential in maximising the functional potential of each individual and therefore reducing their readmissions. Given the current national drive towards 'discharge to assess' and 'early-supported discharge' schemes which looks to shorten the acute length of stay, focussing solely on provision of adequate mobilisation pre-discharge will only support effective care in one small part of the patients' rehabilitation journey. Whilst it is important to have adequate inpatient mobilisation it is equally critical to have appropriate post-discharge rehabilitation, re-ablement and recovery options.an ever-reducing length of stay. It is recommended that individual quality standards are added around referral on for ongoing rehabilitation and provision of evidence-based rehabilitation programmes in community settings. The outcome measures in the NHS Outcomes Framework :- **Improving recovery from fragility fractures** 3.5 Proportion of patients recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days **Helping older people to recover their independence after illness or injury** 3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation service*

ID	Stakeholder	Statement number	Comments
			Could be used to measure the effectiveness of performance against such a quality standard if it were to be added.
2	Royal College of Physicians	General	The RCP is grateful for the opportunity to respond to the above consultation. We have liaised with colleagues in our Falls and Fragility Fracture Audit Programme (FFFAP) and would like to make the following comments. We have also been copied to the response of the British Geriatrics Society and wish to highlight those comments. **List of quality statements** **Statement 1. Adults presenting with hip fracture receive prompt pain management that is based on an assessment of their pain. [2012, updated 2016]** **Statement 2. Adults with hip fracture have surgery on the day of, or the day after, admission under the supervision of senior surgeons and anaesthetists. [2012, updated 2016]** **Statement 3. Adults with displaced intracapsular hip fracture receive cemented arthroplasty, and those who are assessed as clinically eligible are offered a total hip replacement. [2012, updated 2016]** **Statement 4. Adults with hip fracture start daily mobilisation on the day after surgery. [2012, updated 2016]** **Statement 5. Adults with hip fracture are offered a formal orthogeriatric-led Hip Fracture Programme when admitted to hospital. [2012, updated 2016]**
3	Royal College of Physicians	Overall configuration	The primary weakness of this set of quality standards is its focus on a small number of issues which inevitably will be at the exclusion of other standards used in QS16, the framework which the National Hip Fracture Database (NHFD) has used as the national clinical audit for this condition. Systematic change in the quality of care provided to patients with hip fracture has long been constrained

ID	Stakeholder	Statement number	Comments
			by focus on issues confined to the first hours of presentation, at the expense of the weeks that follow – weeks that will determine whether patients die, return home, or require long-term placement. • Statement 1 primarily focuses on the <4 hours that a patient should spend in an emergency department • Statement 2 and 3 on surgery the same or following day • Statement 4 on mobilisation on the day after operation • Statement 5 is the only one with a wider remit, and time constraints mean that discussion, resourcing, and implementation of this quality standard are likely to focus on the first 4, before getting round to the Hip Fracture Programme within which they would all need to operate. The wording of Statement 5 and the proposal for the quality measures that would support it betrays a misunderstanding of the nature of a Hip Fracture Programme (HFP). An HFP is not an intervention or set of interventions that may be 'offered' to an individual patient, but a structure of collaborative working within which the first four Statements (and many others) will be delivered. The HFP was the central recommendation of CG124, and (through its capacity to reduce mortality, reduce length of stay and avoid long-term dependency) the dominant cost-saving strategy for hip fracture care. The current QS proposal appears to place the HFP on a par with four other recommendations which are much more limited in their impact. This failure of emphasis is a missed opportunity. The National Hip Fracture Database (and its commitments to NHS Outcome Indicators, CCG OIs, CQC etc.) have been configured around CG124's recommendation of the HFP, and the current set of quality statements are too diverse to be fit for purpose as a framework around which the national clinical audit for hip fracture can work. We would propose that much of this misplaced emphasis might be addressed by re-ordering the proposed

ID	Stakeholder	Statement number	Comments
			Statements – to recognise that the HFP is an approach that must start when a patient first presents with hip fracture, and improving the proposed structure of quality measures – as explained below.
4	British Geriatrics Society	General	The 5 Standards that have been kept from the longer list in the original 2012 document do represent those areas where there remains most need of improvement, even though all of the original standards are clinically important and valid.
5	Northern Devon Healthcare Trust	General	Overall the principles of the Quality Standards are reasonable but they are not specific or easily measurable. I cannot see that they will drive quality improvement for this patient group.
6	Royal Pharmaceutical Society	General	The Royal Pharmaceutical Society welcomes the quality standard for Hip Fracture (update). However it is important to include the role of the pharmacist in the management of hip fracture from admission in secondary care to final return to the community, in adults (aged 18 years and over). Pharmacists can undertake a number of roles to support patients with the management of hip fracture.
7	Association of Anaesthetists' of Great Britain & Ireland and the Royal College of Anaesthetists	Introduction / Coordinated Services / Training and Competencies (p.6)	At present there are no recognised post FRCA (Fellowship of the Royal College of Anaesthetists) training schemes for anaesthetists who wish to specialise in hip fracture care.
8	The Chartered Society of Physiotherapy	Introduction	The Chartered Society of Physiotherapy (CSP) welcome the opportunity to respond to this consultation. We are especially pleased to see that the quality standard covers management across the whole patient pathway, through to the community setting.
9	National Osteoporosis Society	General	A detailed submission has been made by the Royal College of Physicians which the National Osteoporosis Society supports.
10	Royal College of Radiologists	General	The standards start by stating: 'this quality standard covers the diagnosis and management of hip fracture from admission in secondary care to final return to the community, in adults (aged 18 years and over)'. Despite this statement, the draft quality standard does not comment on diagnostic tests for hip fracture, which the RCR feel is due to an assumption that by the time of admission a fracture will have been

ID	Stakeholder	Statement number	Comments
			diagnosed. This is not always the case and many admitted patients have not been diagnosed with a fracture.
11	Royal College of Radiologists	General	This draft document should re-iterate the requirement for formal confirmation of hip fracture, in line with the NICE guidance which states 'Offer MRI if hip fracture is suspected despite negative X-rays of the hip of an adequate standard. If MRI is not available within 24 hours or is contraindicated, consider CT.' This formal confirmation should be conducted to a time frame that allows surgery on the day of, or day after admission, aligning with the stated course of action in this quality standard (quality statement 2 page 7).
12	Royal College of Nursing	General	Nurses caring for people with hip fractures were invited to review the draft quality standard. There are no further comments to make on this document on behalf of the Royal College of Nursing.
13	Zimmer Biomet	General	Zimmer Biomet has read your draft document and is broadly in agreement with the aims and measurements contained within the draft. Zimmer Biomet developed a Fragility Fracture Quality Improvement Program within which we adopted and integrated the contents of the previous Quality Standard for hip Fracture; NICE Quality Standard 15 issued in March 2012. This incorporates many if not all of the proposed guidelines and measures for assessing Quality of care. The programme encompasses: • Patient and healthcare drivers for improved hip fracture management • Effective interventions • Quality measures • Best Practice Tariff This programme has been in use in a large level 1 trauma centre in the United Kingdom since December 2014 and has accumulated data to both verify the principles enshrined in the guidance and quantify the effectiveness of them in such a clinical environment. This hospital is now a reference centre for the Fragility hip programme with interest in its adoption coming from other clinical centres both in the United Kingdom and Europe. Data is available since its introduction to determine:

ID	Stakeholder	Statement number	Comments
			• improved achievement of Best Practice Tariff, • improved Orthogeri assessment • improved access to surgery and timing of surgical interventions Reduced 30 day mortality, used in collaboration with data collected through the National hip fracture database. Other key indicators are monitored and used to inform improvements such as Length of Stay and Mortality. Our methodology of increasing the quality of care and services offered to patients with hip fractures is based upon a combination of quality and safety improvement, pathway optimisation and operational process efficiency. These are partially achieved through development and integration of standardised clinical protocols for patient optimising prior to and during surgery. These extend into multiple areas such as comorbidity measurement, pain and fluid management and anaesthesia, all of which have the potential to improve the outcome for the patient. We would advocate the use of ring fenced beds in large trauma centres managing hip fractures, constituting a fragility fracture ward. Patients admitted into these beds would be under the supervision of skilled Othogeriatricians who co-manage their assessment for surgery with the Multidiscipline Team (MDT) optimising the patient as appropriate for the agreed surgical procedure with robust post-operative mobilisation and rehabilitation programmes. However in doing so stress is placed on existing operating theatre capacity, potential availability of consultant orthopaedic surgeons to undertake the surgery and capacity within physios and occupational therapies. We would recommend the concept of bed ring fencing / hip fracture wards, whilst not easy to achieve, should be promoted in the guidance document. Evidence from our early implementation of the Fragility hip programme has determined that constructive interaction between the MDT is crucial in achieving successful patient and services improvement outcome and delivering improved quality of care for this patient group. We also note that the impact of delayed patient discharge culminating in longer length of acute hospital stay and the adverse impact this has on quality of life and pressure on acute care resources. We are working with the acute care provider to improve patient discharge routes and access to the right discharge destination at the right time. This aims to reduce variation in length of stay within defined patient groups.

ID	Stakeholder	Statement number	Comments
			Consultation must therefore take place between Orthogeriatricians and the community based services such that all patients who are safe to do so are discharged to the appropriate residence as soon as possible with access to appropriate, co-ordinated rehabilitation support. The proposed guidance promotes the use of total hip arthroplasty, where appropriate in patients with intracapsular fractures. We have adopted and adapted a treatment algorithm to reduce variability and aid decision making for the appropriate method of hip fracture fixation / femoral neck replacement. This provides guided options to treat patients with trochanteric nails, hemiarthroplasty or total hip component, depend on the clinical requirement. Furthermore this algorithm and the Fragile Hip Fracture programme could be made available to NICE for further consideration.
14	NHS England	General	Thank you for the opportunity to comment on the above QS. I wish to confirm that NHS England has no substantive comments to make regarding this consultation.
15	Department of Health	General	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.
16	The Chartered Society of Physiotherapy	Question 1	Yes, we agree that this reflects the key areas for quality improvement.
17	National Osteoporosis Society	Questions for consultation	We are disappointed to see the quality statements selected for this consultation as compared to the previous version of the Quality Standard. We feel that important aspects of care have been omitted in reducing the number of quality statements to 5. Of notable concern are the removal of quality statements relating to secondary fracture prevention (bone health and falls). People who have had a fracture are at increased risk of breaking another bone. Prompt intervention to reduce fracture risk is vital to tackle the growing burden of fragility fractures. This is recognised in TA161 and the Best Practice Tariff for hip fractures, and in the SIGN guideline on osteoporosis. It was also raised by SCM recorded on p.61 of the briefing paper (5 April 2016).
18	National Osteoporosis Society	Questions for consultation	Improvements in hip fracture care in England have been driven by the National Hip Fracture Database and the Best Practice Tariff. We are concerned that there is inadequate consistency between existing quality drivers and this QS on hip fracture.

ID	Stakeholder	Statement number	Comments
19	[King's College Hospital NHS Foundation Trust]	Questions for consultation	Yes I feel that this draft QS accurately reflects the key areas for QI. These areas are priorities for the care of patients at our organisation.
20	RCGP	Question 1	It would be useful to consider community-based rehabilitation post hospital discharge. The 5 areas covered are all important areas to improve the outcomes for patients and their carers. Early surgical fixation, the role of anti-thromboembolic and anti-infective prophylaxis, good pain control at the perioperative, detection and management of delirium, correct urinary tract management, avoidance of malnutrition, vitamin D supplementation, osteoporosis treatment and advancement of early mobilisation to improve functional recovery and falls prevention are basic recommendations for an optimal maintenance of hip fractured patients. Orthogeriatric units, with a medical co-management of these patients, offer the best chance for a successful outcome, reducing length of stay, in-patient problems and mortality, allowing the patient to recover his previous ambulatory state. A further area to consider for inclusion is community-based rehabilitation post hospital discharge interventions which has shown promising results improving various physical function outcomes, mobility, and ADLs function 1 year post-discharge from the hospital for older adults with CI. Further, there is some evidence to suggest that providing outpatient rehabilitation after discharge from inpatient rehabilitation programs can increase the likelihood of the older adults staying home and avoiding institutionalization for a short (3-month) period of time. Chu CH, Paquin K, Puts M, McGilton KS, Babineau J, van Wyk PM Community-Based Hip Fracture Rehabilitation Interventions for Older Adults With Cognitive Impairment: A Systematic Review JMIR Rehabil Assist Technol 2016;3(1):e3 DOI: 10.2196/rehab.5102 Most rehabilitation services for individuals who sustain a hip fracture are not designed to meet the complex needs of those who also have cognitive impairment. There is some evidence that tailored approaches can improve results. Rehabilitation Interventions for Older Individuals With Cognitive Impairment Post-Hip Fracture: A Systematic Review

ID	Stakeholder	Statement number	Comments
			Resnick, Barbara et al. Journal of the American Medical Directors Association , Volume 17 , Issue 3 , 200 - 205
21	The Chartered Society of Physiotherapy	Question 2	Feedback from our members suggests that local systems and structures are in place locally, and that they also source information from the National Hip Fracture Database. However, it should be noted that local systems may not be identical across the different clinical commissioning groups.
22	[King's College Hospital NHS Foundation Trust]	Questions for consultation	Yes – on Denmark Hill site have created an site database that collects these relevant metrics - orthogeriatric team, who look after patients directly, collect the data.
23	RCGP	Question 2 to 5	They are predominantly secondary care based so the RCGP has no comments to make on these.
24	[King's College Hospital NHS Foundation Trust]	Questions for consultation	Yes – will need to submit to local practice collection
25	The Chartered Society of Physiotherapy	Question 4	As indicated in the document, the availability of rehabilitation is variable, and not all services are resourced for this level of input. Therefore, this would require resourcing but would then have anticipated cost savings from decreased length of stay, social care costs, complications secondary to prolonged immobility and hospital readmissions
26	The Chartered Society of Physiotherapy	Question 4	We feel that the Hip Fracture Programme (multidisciplinary input across the pathway) will be difficult to achieve when this will require management, ownership, and governance across more than one organisation. Integration would undoubtedly help with this, but many services remain fragmented.
27	[King's College Hospital NHS Foundation Trust]	Questions for consultation	Yes – cost savings from better mobility and reduced length of stay.
28	Royal College of Physicians	Statement 1	**Adults presenting with hip fracture receive prompt pain management that is based on an assessment of their pain.** **Proposed changes to Quality Measures** ~~b) Proportion of presentations of hip fracture in which the person is given paracetamol as first-line~~

ID	Stakeholder	Statement number	Comments
			~~analgesia on admission.~~ ~~d) Proportion of surgeries for hip fracture where the person receives paracetamol as first-line analgesia every 6 hours preoperatively.~~ ***Comment:*** *We suggest removing these measures – they serves no purpose as a quality measure and distracts from measures with more potential to identify high quality care (as below)* *Paracetamol data will not be captured by the NHFD – they would be inappropriate for inclusion in our dataset as there is no evidence that any hospital does anything except follow this element of CG124.* *Similarly they did not form part of the College of Emergency Medicine audit. Local data collection on this topic will never be prioritised for the same reasons and because local hip fracture audit will not be performed in a field already covered by a national clinical audit* **Proposed replacement Quality Measures:** d) Proportion of people with hip fracture who receive a nerve block in the Emergency Unit or orthopaedic ward as part of individualised preoperative pain management. e) Proportion of people with hip fracture who receive a nerve block in the operating theatre as part of an individualised approach to post-operative pain management. ***Comment:*** *CG124 was clear that nerve blocks should be considered as one approach to analgesia.* *Provision around the country varies enormously with many units providing this to only a small proportion of people – suggesting that assessment based analgesia is <u>not</u> being provided in these units.* *Nerve blocks are already an element of NHFD work, and serve to identify high quality care, in a way that*

ID	Stakeholder	Statement number	Comments
			laboriously recording 100% provision of paracetamol will not.
29	British Geriatrics Society	Statement 1	'Immediate' is an essentially unauditable concept in this context. Please specify a maximum time between registration and first assessment of pain.
30	British Geriatrics Society	Statement 1	We would ask that an additional quality measure is included measuring the proportion of patients receiving nerve blocks as part of early pain relief. Regional analgesia reduces the need for opiates and therefore minimises the potential for side effects compared to systemic analgesia.
31	Northern Devon Healthcare Trust	Statement 1	This should be more specific in terms of pain assessment, pain management modalities (simple analgesia, opiate analgesia & nerve blocks) and also clinical outcome measurement (ie emphasis on making patient pain free)
32	Royal Pharmaceutical Society	Pain management	There is mention of healthcare professionals (such as specialists and nurses) being involved in pain management. We would recommend that pharmacists are included in this category of healthcare professionals. They could be involved in the advising and prescribing of medication to treat pain in the hip fracture ward, as well as in the peri-operative period.
33	Association of Anaesthetists' of Great Britain & Ireland and the Royal College of Anaesthetists	Statement 1: Pain Management / Quality Measures (p.9-12)	1. Analgesia is dealt with only in terms of simple analgesia – paracetamol. There is excellent evidence for the use of nerve blocks in these patients pre and post op resulting in the reduction of opiate use and associated complications. Paracetamol alone is unlikely to be sufficient to manage pain in this patient group in the pre-op and immediate post-op phase. 2. Analgesia is only dealt with pre-op "…pain relief quickly after fracturing their hip and until their operation." In order to facilitate mobilisation post-op this analgesia assessment and treatment should continue post-op.
34	Association of Anaesthetists' of Great Britain & Ireland and the Royal College of Anaesthetists	Statement 1: Pain Management (p.9-12)	Details of the pain assessment tools that are going to be used must be forthcoming.
35	Orthopaedic Trauma Society	Statement 1	This is very generic. If to be measurable needs to be related to a specific intervention eg fascia iliaca block. Pin relief also needs to be provided not on basis of assessment of existing pain but on an estimation of

ID	Stakeholder	Statement number	Comments
			likely pain. The original guideline drew the distinction between static pain (ie at rest) and the dynamic pain anticipated in moving a patient for x-rays or personal care
36	[British Orthopaedic Association]	Statement 1	How will the assessment and efficacy of analgesia be measured? How will this statement in itself improve standards and not become a tick for all trusts?
37	AGILE	Statement 2	Outcome measures stated here are not attributable, either in part of solely to whether a senior surgeon is present during surgery to provide supervision. These should therefore be removed :- • Pain control following fracture • Post-operative delirium • Length of stay • Return to pre-hip fracture place of residence.
38	Royal College of Physicians	Statement 2	**Adults with hip fracture have surgery on <u>planned trauma lists on</u> the day of, or the day after, admission under the supervision of senior surgeons and anaesthetists.** ***Comment****: Prompt surgery of hip fracture patients remains a key area for improvement.* *The statement should include wording to reinforce the value of planned trauma lists or 'hip fracture' lists.* *Approximately 12% of all hip fracture patients miss this target due to a lack of theatre resources.* *Operational definitions of 'senior' and 'supervision' should be considered to ensure that practice is able to be measured consistently, both locally and by the national audit.* *National audit data (currently unpublished) from NHFD suggests that 81.7% of cases are supervised by a senior (consultant or associate specialist) anaesthetist and just less than three-quarters (74.92%) by a senior surgeon.*
39	British Geriatrics Society	Statement 2	There is inconsistency between NICE's definition of prompt surgery (on day of or after admission) and the BPT definition (within 36 hours). Given that the NICE definition can mean anything from 24 hours and 1 minute to 47 hours and 59 minutes, depending on time of admission, we would ask that the definitions are

ID	Stakeholder	Statement number	Comments
			made consistent and that 36 hours is used universally.
40	British Geriatrics Society	Statement 2	Please include a definition of 'senior' in this context. Presumably this means consultant grade and associate specialist, or does it include more senior training grades? It would seem sensible to use the same definition as NHFD, which is now collecting this data.
41	British Geriatrics Society	Statement 2	Please specify which post-operative complications, as this would need to be either a tightly defined list (if there was a desire for sites to produce comparable data) or a broad definition (which would only be suitable for local audit).
42	British Geriatrics Society	Statement 2	Please provide a more specific definition of post-operative delirium if there is a desire for sites to produce comparable data. Currently, the NHFD is recommending the use of 4AT (which is a screening test, not a diagnostic test for delirium) and does not specify how soon following surgery this should be performed. Delirium can be diagnosed by experiences clinicians without necessarily using a screening test in all cases and delirium can present immediately after surgery or after several days, for different reasons.
43	British Geriatrics Society	Statement 2	Please specify whether this is acute spell, super-spell, or both, if there is a desire for sites to produce comparable data.
44	British Geriatrics Society	Statement 2	Please specify if this means discharge directly from hospital or following rehabilitation/enablement, as many local areas will transfer care of some patients to a non-NHS provider before the patient returns home. (If there is a desire for sites to produce comparable data)
45	British Geriatrics Society	Statement 2	Please specify a time point at which mortality is to be measured, if there is a desire for sites to produce comparable data.
46	British Geriatrics Society	Statement 2	The NHFD ASAP audit found that a senior surgeon and anaesthetist was present at 91.7% of operations, where the grade was recorded. Therefore there is a small amount of room for improvement.
47	Northern Devon Healthcare Trust	Statement 2	This should include type of list (ie planned trauma list, including weekend cover) and the remainder of the clinical team in theatres.
48	Association of Anaesthetists' of Great Britain & Ireland and the Royal College of Anaesthetists	Statement 2: Timing of Surgery with Senior	Definition needed of "senior" surgeon and anaesthetist in Statement 2. "Seniority" is less important than "competency".

ID	Stakeholder	Statement number	Comments
		Supervision (p.13-17)	
49	Association of Anaesthetists' of Great Britain & Ireland and the Royal College of Anaesthetists	Statement 2: Timing of Surgery with Senior Supervision (p.13-17)	There should be standardised perioperative data entry of this element as in other Healthcare Quality Improvement Partnership (HQIP) sponsored national audits. For hip fracture, the GMC numbers of the anaesthetist(s) and surgeon(s) who were responsible for the care of the case should be entered. We expect these to be individuals on the specialist register.
50	Association of Anaesthetists' of Great Britain & Ireland and the Royal College of Anaesthetists	Statement 2: Timing of Surgery with Senior Supervision / Quality Measures (p.13-17)	Need definition of "postoperative delirium" in Standard 2 outcomes - isn't this a "postoperative complication"? As 4AT is being collected by the National Hip Fracture Database (NHFD), should NICE support the use of this over CAM, given the evidence for its use specifically in hip fracture compared to CAM? It would be useful to standardise the collection tool nationally. (See later collection of all perioperative data should be standardised). We are glad to see period delirium feature, but given its prevalence and financial consequences, and the fact that we now have an assessment tool, we wonder whether delirium is worth a separate Quality Statement?
51	Association of Anaesthetists' of Great Britain & Ireland and the Royal College of Anaesthetists	Statement 2: Timing of Surgery with Senior Supervision (p.13-17)	In reference to Question 2 on page 7: Are local systems and structures in place to collect the data for the proposed quality measures? If not, how feasible would it be for these systems and structures to be put in place? The answer is NO. Data collection is different in each trust. Anaesthesia data collection via NHFD is only voluntary. In our view, the currently voluntary anaesthesia/perioperative care elements of the NHFD dataset should become mandatory. Furthermore, (see above) perioperative data should be entered in real time, as the procedure takes place, like the National Emergency Laparotomy Audit (NELA) and the National Joint Registry (NJR) in order to allow more rapid feedback of results to local sites.

ID	Stakeholder	Statement number	Comments
52	Association of Anaesthetists' of Great Britain & Ireland and the Royal College of Anaesthetists	Statement 2: Timing of Surgery with Senior Supervision (p.13-17)	Must be very clear how "postoperative stay" or "hospital stay" are defined. Must have a definition which includes the effects of senior input and the overall organisational effects.
53	Orthopaedic Trauma Society	Statement 2	The guideline was specific in not applying seniority and adequacy to only surgeon and anaesthetist. The cases need to be done an a planned trauma list with adequately trained or supervised personnel in each of the disciplines involved, eg scrub staff, radiographer, surgeon and anaesthetist
54	[British Orthopaedic Association]	Statement 2	These patients should be treated on planned lists rather than adhoc emergency/out of hours lists and this should be stated.
55	[King's College Hospital NHS Foundation Trust]	Questions about the individual QS	Yes -
56	Royal College of Physicians	**Statement 3**	**Adults with displaced intracapsular hip fracture receive cemented arthroplasty, and those who are assessed as clinically eligible are offered a total hip replacement.** ***Comment****: Statement 3 highlights two areas of concern but neglects the role of surgery in half of all patients, who have extra capsular fractures.* *There has been a year on year fall in the proportion of intertrochanteric fractures treated according to CG124* *Statement 8 from QS16 should be considered for incorporation into this statement:* *People with trochanteric fractures above and including the lesser trochanter (AO classification types A1*

ID	Stakeholder	Statement number	Comments
			and A2) receive extramedullary implants such as a sliding hip screw in preference to an intramedullary nail. *More detailed clarity on the operational definitions of eligibility – in particular around fitness for surgery and anaesthesia – would be required in order that consistent protocols can be established nationally.*
57	British Geriatrics Society	Statement 3	We agree that the evidence supports the use of cemented prostheses, though some hospitals find that the additional theatre time is a pressure on resources. There is growing concern among clinicians and Coroners about the risk of cement implantation syndrome (CIS). We ask whether the QS should include a statement that patients should be specifically counselled about the risk of CIS and whether selected patients, those with severe cardiac or respiratory disease, should be given the option of an uncemented prosthesis.
58	British Geriatrics Society	Statement 3	We agree that some patients are not offered total arthroplasty when they should be. However, the definition of 'clinically eligible' is overly simplistic. In particular the concept of 'medically fit' for the procedure is difficult to define. In addition, patient choice is not considered. Patients choosing not to have a total arthroplasty should not be included in these process measures.
59	Northern Devon Healthcare Trust	Statement 3	This should encompass all types of hip fracture and preferably extend to other proximal femoral fractures (eg devices for extracapsular fractures).
60	Association of Anaesthetists' of Great Britain & Ireland and the Royal College of Anaesthetists	Statement 3: Intracapsular Fracture (p.18-21)	No mention of Bone Cement Implantation Syndrome (BCIS) and the AAGBI/BSOA/BGS safety guideline, "Reducing the risk from cemented hemiarthroplasty for hip fracture" (published February 2015). Up to 160 patients may be dying each year and full implementation of the safety guideline should be a priority for NICE and NHFD. All hemi-arthroplasties should be added to the NJR, so an accurate picture of who is doing the surgery can be obtained, unless real time data entry for the perioperative period in hip fracture is started (see above).
61	Association of Anaesthetists' of Great Britain & Ireland and the Royal College of Anaesthetists	Statement 3: Intracapsular Fracture / Resource Impact	Simplistic arguments that THR is cheaper than hemi-arthroplasty and the hospital tariff was the same for both. THR as an implant costs more and needs more theatre time. There is no significant reduction in the readmission or re-operation rate from the RCTs. The idea that a THR is cheaper is that generally this is done on the fitter and healthier patients, who mobilise and go home quickly. If they extend the indications then this will just incur extra costs as those who would have had a hemi-arthroplasty will have a THR and will take longer to rehabilitate. The only advantage is that they will be entered onto the NJR, hemi-

ID	Stakeholder	Statement number	Comments
		Considerations (p.18-21)	arthoplasties are not (currently). Very careful attention must be paid to the BCIS guidelines (see above).
62	Orthopaedic Trauma Society	Statement 3	There is no logical reason to single out the displaced intra-capsular fracture alone for a quality standard. The surgical standards for the other fractures extra-capsular, A1/A2, the subtrochanteric and A3 should be referred to as well. Possibly with the single standard of "adhere to the NICE surgical hip fractures recommendations".
	[British Orthopaedic Association]	Quality Statement 3 (statement)	This is a surgery standard and should include extracapsular fracture guidance in addition to the intracapsular guidance given i.e. A1/A2 fractures sliding hip screw, A3 and subtrochanteric fractures intramedullary device.
63	University Hospital North Midlands NHS Trust	Statement3	Uncemented hemiarthroplasties such as the Thompson prosthesis for displaced intracapsular fractures, have a very useful place but have been excluded in this statement. As a revision Arthroplasty surgeon I recommend that the adjective 'cemented' be removed to reduce the potential harm it could cause to a subset of patients by Bone Cement Implantation Syndrome BCIS. Furthermore patients at higher risk of infection would face a more complex revision if their hemiarthroplasty became infected.
64	AGILE	Quality Standard 4	Economic analysis is too weak in this section to be confident about the assumptions included :- This is based on the following assumptions: ❑ Mobilisation involves a physiotherapist or occupational therapist. ❑ Around 70% of people with hip fracture already receive daily mobilisation. ❑ Around 90% of people with hip fracture are expected to receive daily mobilisation in the future. ❑ An average of 8.5 hours of physiotherapist time is needed per patient, costing £235. ❑ An average of 5 hours of occupational therapist time is needed per patient, costing £138 The duration of time over which the number of physiotherapy and occupational therapy hours are needed is not clear. E.g. is it 8.5 hours over an average 14 day length of stay / 10 day LOS / 5 day LOS.
65	Royal College of Physicians	**Statement 4**	**Adults with hip fracture start daily mobilisation <u>BY</u> the day after surgery.**

ID	Stakeholder	Statement number	Comments
			Comment: *The current form of Standard implies that mobilisation should wait <u>until</u> the following day, this is not necessarily so and would prejudice prompt mobilisation of many individuals. Hence the above proposed rewording.* **Proposed rewording for Rationale** Early restoration of mobility after hip fracture surgery can be beneficial for the person because it can reduce the length of hospital stay and avoid the complications of prolonged bed confinement. People with hip fracture should receive individualised attention to blood transfusion, fluid resuscitation and analgesia to ensure that early mobilisation is possible. <u>Physiotherapist assessment</u> should guide support with mobilisation which should be offered to people at least every day while they are in hospital and should continue once they are discharged from hospital. ***Comment*****:** physiotherapist assessment is a specific recommendation in CG124 **Proposed rewording for Quality Measures:** **Structure** Evidence of local arrangements to ensure that people who were mobile before their hip fracture are able to start daily mobilisation by the day after surgery. **Process** Proportion of people who were previously mobile who start daily mobilisation by the day after surgery. ***Comment:*** *it is important to remove reference to "contraindications". This measure is incompatible with the approach that the NHFD is taking. "Contraindications to mobilisation" are precisely what this Standard*

ID	Stakeholder	Statement number	Comments
			should be challenging – it should not just be a test of physiotherapy staffing levels. *For example:* *a. Some departmental policies continue to routinely limit groups patients to non-weight bearing which for many precludes mobilisation* *b. Some departments continue to delay mobilisation while awaiting a "check X-ray"* *c. Some departments have poor structures for post-operative analgesia that either over treat (causing delirium) or undertreat (so patients are too sore to mobilise)* *d. Some departments have poor structures for post-operative fluid and blood transfusion so mobilisation is commonly contraindicated by blood pressure concerns* *All of these issues represent poor quality care and need to be challenged by this Standard*
66	British Geriatrics Society	Statement 4	Please specify what mobilisation should consist of on the first post-operative day. The NHFD records the number of patients mobilised out of bed and makes no allowance for patients that have contraindications to mobilisation. However, some hospitals report well over 90% of patients achieving this standard, which seems too good to be true.
67	British Geriatrics Society	Statement 4	Please specify at what point following surgery the patient's mobility should be assessed, if there is a desire for sites to produce comparable data.
68	Northern Devon Healthcare Trust	Statement 4	Rehab is not just day one. A comprehensive rehab programme to discharge should be in place and the clinical outcomes should be measured (eg return to previous level of function)
69	Association of Anaesthetists' of Great Britain & Ireland and the Royal College of Anaesthetists	Statement 4: Mobilisation After Surgery / Quality	Why first mobilisation on the day *after* surgery? Should this be changed to first mobilisation *no later than* the day after surgery?

ID	Stakeholder	Statement number	Comments
		Measures (p.22-25)	
70	Association of Anaesthetists' of Great Britain & Ireland and the Royal College of Anaesthetists	Statement 4: Mobilisation After Surgery / Quality Measures (p.22-25)	Process measures for remobilisation should include "Proportion of hip fracture surgeries after which people are not able to start daily mobilisation on the day after surgery because of pain. Numerator - the number of people who do not start daily mobilisation no later than the day after surgery because of pain. Denominator - the number of hip fracture surgeries after which the person has no contraindications for physiotherapy."
71	Association of Anaesthetists' of Great Britain & Ireland and the Royal College of Anaesthetists	Statement 4: Mobilisation After Surgery (p.22-25)	Post-operative pain is a contraindication to mobilisation. Addition of a process to ensure post-op pain is addressed may improve the likelihood of early mobilisation as well as improving patient experience.
72	Orthopaedic Trauma Society	Statement 4	This is very weak. Mobilisation on day one post operation should be the beginning of a programme of mobilisation. This standard would encourage that single day of mobilisation to become a tick box end in itself
73	The Chartered Society of Physiotherapy	Statement 4 (whole section)	Whilst we welcome the focus on early movement, we would suggest using "rehabilitation (including mobilisation)" instead of "mobilisation" alone. There is already confusion amongst health care professionals as to what is meant by the term "mobilisation", with many different interpretations of the term, for example, movement of a limb, transfer to a chair, or walking. Whilst a description of mobilisation is provided in the section titled "What the quality statement means for patients, service users and carers", this description is more reflective of rehabilitation rather than mobilisation. The World Health Organisation define rehabilitation as "a process aimed at enabling people to reach and

ID	Stakeholder	Statement number	Comments
			maintain their optimal physical, sensory, intellectual, psychological and social functional levels". Using the term "rehabilitation" is also more reflective of every aspect of the patient pathway, whereby the whole multidisciplinary team has a role to play. Early assessment by a physiotherapist is a key component of rehabilitation.
74	The Chartered Society of Physiotherapy	Statement 4 (whole section)	To encourage early mobilisation/rehabilitation and for consistency with the National Hip Fracture Database we suggest wording throughout the section is changed to daily mobilisation/rehabilitation *on the day of or day following surgery.*
75	The Chartered Society of Physiotherapy	Rationale	We suggest adding information on rehabilitation (with a definition) in this section.
76	The Chartered Society of Physiotherapy	Quality measures - process	We recommend an additional process measure – the proportion of hip fracture surgeries after which people are assessed by a physiotherapist on day of or day after surgery. Data source: Local data collection and National Hip Fracture Database
77	The Chartered Society of Physiotherapy	Quality measures - process	The phrase "Contraindications for physiotherapy" is misleading – physiotherapy itself is unlikely to be contraindicated, but rather the specific treatment techniques physiotherapy may entail. It would be more accurate to state "contraindications to rehabilitation".
78	The Chartered Society of Physiotherapy	What the quality statement means for patients, service users and carers	We welcome the explanation of what the exercises would entail, but suggest adding "balance" as this is also an integral aspect to being able to mobilise. The explanation could read "the exercises (*part of rehabilitation*) are to improve movement, strength, *balance and functional activity*"
79	[British Orthopaedic Association]	Quality Statement 4 (statement)	Same reservations as Statement 1. How do you avoid this becoming a simple tick for all? The standard needs to be more robust.
80	The Society and College of Radiographers	statement 4:	Mobilisation after surgery Quality measures: structure Particular attention should be paid to access to post op radiographic imaging that may be required prior to mobilisation including the need for appropriate and timely transport and nursing support for the

ID	Stakeholder	Statement number	Comments
			examination.
81	Royal College of Physicians	**Statement 5**	**Adults with hip fracture <u>are cared for within</u> a formal orthogeriatrician-led Hip Fracture Programme <u>from admission</u> to hospital.** ***Comment****: we propose the above rewording as the HFP is not an intervention, it is a model within which all elements of care are integrated* **Proposed rewording of rationale** Hip fracture patients often have comorbidities and complex care needs. The multidisciplinary <u>approach</u> of the Hip Fracture Programme, with regular assessment and continuous rehabilitation, has been found to better meet those needs and lead to reduction in mortality and readmission to hospital. In addition, the orthogeriatrician has a key role in the integration of initial assessment and perioperative care as most people with hip fracture have comorbidities. ~~This does not apply to people with high-energy hip fracture~~. ***Comment:*** *Remove the last phrase - the HFP <u>should</u> apply to patients suffer a high energy injury, their care will only differ in that they do not trigger a need for secondary prevention of falls and fragility fracture.* **Proposed rewording of Quality Measures** **Proposed rewording for Structure** Evidence of local arrangements to ensure that people with hip fracture are <u>cared for within</u> a formal orthogeriatrician-led Hip Fracture Programme <u>from admission</u> to hospital.

ID	Stakeholder	Statement number	Comments
			***Comment**: Proposed rewording to better express the nature of an HFP* **Proposed changes to Process measures** ~~a) Proportion of presentations of hip fracture where the person receives care through a formal orthogeriatric-led Hip Fracture Programme on admission to hospital.~~ ***Comment:** This information does not exist within the NHFD or any other data source. It would be more appropriate to remove this measure altogether, and use more objective measures (as defined below) to operationalise the definition of an HFP. Otherwise hospitals simply claim that their patients receive HFP care – with no evidence to support this assertion* b) Proportion of presentations of hip fracture where the person receives pre-operative orthogeriatric assessment. c) Proportion of presentations of hip fracture where the person receives pre-operative orthogeriatric assessment leading to prompt surgery ***Comment:** These two proposed measures are readily measured by the NHFD and would serve to profile orthogeriatric involvement in early assessment and optimisation of patients* e) Proportion of presentations of hip fracture where the person has regular orthogeriatric and multidisciplinary review. Numerator – the number in the denominator where the person's care is reviewed in at least weekly

ID	Stakeholder	Statement number	Comments
			orthogeriatrician-led multidisciplinary team meetings ***Comment:*** *The ongoing nature of orthogeriatric care is fundamental to an HFP, it is not just sufficient to make the initial assessment required for Best Practice Tariff – patients require coordinated multidisciplinary care* f) Proportion of presentations of hip fracture where the person receives orthogeriatric assessment to guide the prevention of future falls and fragility fractures. ***Comment:*** *This proposed additional measure is another integral element of orthogeriatric care in an HFP, which would also fit with NHFD's commitment to helping implementation of CG161 and TA161, and avoid loss of focus on secondary prevention that the previous QS16 provided (unless a QS Statement on secondary prevention is to be included to specifically address this area of hip fracture care)* g) Proportion of presentations with hip fracture where the person is transferred from hospital for early supported discharge or intermediate care for whom the Hip Fracture Programme team makes (and documents the reasons for) this decision. h) Proportion of presentations with hip fracture where the Hip Fracture Programme demonstrates clinical governance supervision of the whole care pathway (Proposed numerator – the number of people for whom the Hip Fracture Programme team is able to report on whether the patient returned to their original residence after inpatient and subsequent rehabilitation care) ***Comment:*** *These are key elements of HFP activity as defined in CG124 (1.8 – Multi-disciplinary Management), and are already a focus for NHFD data collection as part of its work to support CG124 uptake.*
82	British Geriatrics Society	Statement 5	Please define 'rapid'. Presumably this means pre-operative medical assessment?

ID	Stakeholder	Statement number	Comments
83	British Geriatrics Society	Statement 5	Please define 'early'. Presumably this means an OT assessment by the end of the first working day after surgery, or similar?
84	British Geriatrics Society	Statement 5	Very few Hip Fracture Services include geriatrician-led input into post-discharge care in the community. We feel this is often contractually and logistically unachievable – some acute hospitals have more than 10 potential rehabilitation providers. There is also no robust evidence that this is an important or beneficial part of an orthogeriatric service.
85	Northern Devon Healthcare Trust	Statement 5	This "standard" is extremely non-specific. All Trusts will nominally have an "ortho-geriatrician led" programme but this does not specify how much involvement they should have or what their role includes. It does not include falls prevention, bone health or return to function for the patient.
86	Royal Pharmaceutical Society	Multidisciplinary management	We suggest that pharmacists are involved in the Formal Orthogeriatric-led Hip Fracture Programme on admission to hospital. As mentioned Hip fracture patients often have co-morbidities and complex care needs. Pharmacists could carry out medication reviews following a fall. The British Geriatrics Society (BGS) 2014 recommends medication review as a fall may be a sign of frailty with low physiological reserve and where inappropriate medicines may worsen health outcomes. BGS suggests medication reviews could be structured using STOPP START tools, validated for inappropriate prescribing in the elderly. NICE and best practice guidance (NSF; Fallsafe, BSG 2014) suggest medication review as part of multi-factorial assessment of older people with falls risk NOS clinical standards for Fracture Liaison services include recognition of the input of pharmacists We suggest that the multidisciplinary team includes a specialist pharmacist in bone health and falls prevention, who would also need to lead on medicines to control any co-morbidities, pain control in the hip fracture ward and the peri-operative period, supervising the prescribing of the orthogeriatrician leading on the patient care, or leading on the prescribing. References to support the inclusion of a pharmacist:

ID	Stakeholder	Statement number	Comments
			• Fit for Frailty. Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings. Published by the British Geriatrics Society in association with the Royal College of General Practitioners and Age UK. 2014 http://www.bgs.org.uk/campaigns/fff/fff_full.pdf • Falls: assessment and prevention of falls in older people. NICE guidelines CG161 Published: June 2013 http://www.nice.org.uk/guidance/cg161/chapter/recommendations • National Service Framework Older People. DH March 2001. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198033/National_Service_Framework_for_Older_People.pdf • NOS clinical standards for Fracture Liaison services include recognition of the input of pharmacists https://www.nos.org.uk/document.doc?id=1941
87	Association of Anaesthetists' of Great Britain & Ireland and the Royal College of Anaesthetists	Statement 5: Multidisciplinary Management / Quality Measures (p.26-31)	The term "optimisation" in Statement 5 should be removed, as this encourages excessive and unnecessary treatment before surgery. Instead, prefer "normalisation" as in "Proportion of presentations of hip fracture where the person receives rapid *normalisation* of *their* fitness/physiology, for surgery". This also raises the issue of how patients are categorised, the ASA (American Society of Anaesthesiologists) classification system is too crude to be of any value. We recommend the Nottingham Hip Fracture Score should be calculated and risk obtained on every patient before surgery, as happens in the NELA study (currently using POSSUM).
88	Association of Anaesthetists' of Great Britain & Ireland and the Royal College of Anaesthetists	Statement 5 Multidisciplinary Management (p.26-31)	There should be a dedicated cohort of consultant anaesthetists who are involved in the perioperative management of hip fractures. This is not a role for the part time practitioner. Hip fracture fellowships should be developed to train the next generation of consultant, with time spent in orthogeriatrics.
89	Association of Anaesthetists' of Great Britain & Ireland and the Royal College of Anaesthetists	Statement 5 Multidisciplinary Management (p.26-31)	At no point in the entire document is high dependency care mentioned. Consideration should be given to an area where high-risk patients (see risk stratification above) can be monitored and investigated before and after surgery.

ID	Stakeholder	Statement number	Comments
90	Association of Anaesthetists' of Great Britain & Ireland and the Royal College of Anaesthetists	Statement 5 Multidisciplinary Management / Quality Measures (p.26-31)	"Rapid optimisation of fitness for surgery" what does this mean? Without clarity of what this is it will be difficult to measure/record. Perhaps "management (diagnosis and appropriate treatment) of acute medical conditions".
91	Orthopaedic Trauma Society	Statement 5	A woolly statement which lends itself to a paper exercise in ticking a box to record a hip fracture programme has been initiated without any tangible physical benefit to the patient.
92	The Chartered Society of Physiotherapy	Statement 5 (whole section)	This statement is inconsistent with the introduction, which is explicit about covering patient management across the whole patient pathway. However, the core of the statement is very focussed on acute admission to hospital. The importance of care across the whole pathway could be given higher prominence by featuring in the statement itself e.g. Adults with hip fracture are offered a formal orthogeriatric-led Hip Fracture Programme *across all stages of the pathway of care.*
93	The Chartered Society of Physiotherapy	Quality measures - process	Measures a), d) and e) may not be collected locally and are not routinely collected in the National Hip Fracture Database. An alternative measure could be: the proportion of patients of hip fracture where the person has multidisciplinary rehabilitation team assessment. This data is collected in the National Hip Fracture Database.
94	The Chartered Society of Physiotherapy	Quality measures - Outcome	We would recommend two additional measures of outcome: return to the pre-hip fracture place of residence and return to the pre-hip fracture level of mobility.
95	[British Orthopaedic Association]	Quality Statement 5 (statement)	Same reservations again. This is a simple tick box and standard needs to be far more robust and didactic if going to drive quality improvement.
96	Amgen Ltd	General	The draft Hip Fracture Quality Standard covers the diagnosis and management of hip fracture from admission to secondary care to final return to the community in adults 18 years and over. It is noteworthy that the quality statements to not include referral to a fracture liaison service for assessment of bone health and secondary prevention treatment. In the National Hip Fracture Report 2015,1 in audit section 12. **People with hip fracture are offered a**

ID	Stakeholder	Statement number	Comments
			bone health assessment to identify future fracture risk and offered pharmacological intervention as needed before discharge **from hospital** - In 2014 it found that 80.1% of patients had been started on bone protection treatment, or were referred for dual X-ray absorptiometry (DXA) scan or bone clinic assessment. The report acknowledged that there was considerable variation between hospitals and that there is a need for greater consistency if the potential reductions in the rates of further fractures are to be achieved nationally. **Early** Although Trusts have done well at starting patients on bone protection treatments, it is important to ensure compliance and then maintain that treatment. There should be a follow up within 4 months to identify issues with compliance or side effects.2 It well know that compliance is poor with oral bone protection and can be as low as 32% at 1 year from initiation4 also to realise the anti-fracture benefits of treatment a compliance of > 80% is needed.5 A reassessment of fracture risk should take place at around 5 years.3 The National Osteoporosis Society Clinical standard for fracture liaison services2 state that: 1 All patients aged 50 years and over with a new fragility fracture or a newly reported vertebral fracture will be systematically and proactively identified. 2 Patients will have a bone health assessment and their need for a comprehensive falls risk assessment will be evaluated within 3 months of the incident fracture. 3 All patients identified will be offered written information about bone health, lifestyle, nutrition and bone-protection treatments. 4 Patients at increased risk of further fracture will be offered appropriate bone-protection treatments. 5 Patients at increased risk of further falls will be referred for appropriate assessment or interventions to reduce future falls. We would therefore like to request that quality statement 5 is broadened to incorporate referral to a fracture liaison service for formal assessment of risk of a secondary fracture, assessment of bone health and where appropriate, bone protection treatments. The Quality Measure associated with this statement should include: □ Proportion of presentations of hip fracture where the person is referred to a Fracture Liaison Service

ID	Stakeholder	Statement number	Comments
			prior to discharge from hospital. In order to ensure comprehensive management and continuity the following NICE guidance should be referred to osteoporotic fragility fracture prevention (NICE technology appraisals guidance 204, 161 and 160), falls (NICE clinical guideline 21), pressure ulcers (NICE clinical guideline 29),nutrition support (NICE clinical guideline 32), dementia (NICE clinical guideline 42), surgical site infection (NICE clinical guideline 74), venous thromboembolism (NICE clinical guideline 92) and delirium (NICE clinical guideline 103. ***References:*** *1. National Hip Fracture Database Report 2015 http://www.nhfd.co.uk/nhfd/nhfd2015reportPR1.pdf* *2. Effective Secondary Prevention of Fragility Fractures: Clinical Standards for Fracture Liaison Services https://www.**nos**.org.uk/* *3. National Osteoporosis guideline group Guideline for the diagnosis and management of osteoporosis in postmenopausal women and* *men from the age of 50 years in the UK Updated https://www.shef.ac.uk/NOGG/NOGG_Pocket_Guide_for_Healthcare_Professionals.pdf* *4. Lin le et al. Persistence with osteoporosis medications among postmenopausal women in the UK General Practice Research Database* *2011. Menopause: The Journal of The North American Menopause Society Vol. 19, No. 1.* *5. Siris et Al. Impact of Osteoporosis Treatment Adherence on Fracture Rates in North America and Europe. The American Journal of* *Medicine, Vol 122, No 2A, February 2009*

Registered stakeholders who submitted comments at consultation

- AGILE
- Amgen Ltd

- Association of Anaesthetists of Great Britain
- British Geriatrics Society
- British Orthopaedic Association
- Chartered Society of Physiotherapy
- Department of Health
- King’s College Hospital NHS Foundation Trust
- National Osteoporosis Society
- NHS England
- North Devon District Hospital
- Orthopaedic Trauma Society
- Royal College of GPs
- Royal College of Nursing
- Royal College of Physicians
- Royal College of Radiologists
- Royal Pharmaceutical Society
- The Society and College of Radiographers
- University Hospital North Midlands NHS Trust
- Zimmer biomet