

# United They Stand

## Co-ordinating Care for Elderly Patients with Hip Fracture

In 1995 the Audit Commission published a report on co-ordinating care for elderly patients with hip fracture, *United They Stand*, which identified several problems.

- patients had to wait for lengthy periods to be assessed in some accident and emergency (A&E) departments
- waiting more than 24 hours for an operation was not uncommon
- operations were cancelled, sometimes more than once
- some operations were carried out by unsupervised junior surgeons or anaesthetists
- specialists in caring for elderly patients were not always involved in cases of hip fracture
- few trusts organised effective rehabilitation and discharge

This update examines the changes that have taken place between the audits in 1995 and a follow-up survey in 1999. There have been improvements in certain areas.

- 75 per cent of departments have special procedures to fast-track hip fracture patients through A&E

But, while some trusts have made improvements, performance overall remains almost static and recommended best practice is not always followed.

- only 7 per cent of patients (18 per cent in Wales) are admitted to hospital from A&E within one hour
- one-half of patients wait more than 24 hours for their operation, the same as in 1995
- 43 per cent of trusts cancel operations for potentially avoidable reasons
- joint ward rounds between physicians and orthopaedic surgeons are carried out in only 23 per cent of trusts
- 29 per cent of patients are not mobilised within 48 hours of their operation

Trusts should consult their auditors to compare their performance with other trusts and identify those areas most in need of improvement. They should analyse the reasons for any shortfalls in the level of service provided and implement policies to overcome them. Realistic, but challenging, targets should be set and performance against them regularly monitored.

### Value-for-money indicators

*This update is part of a series that tracks progress on a number of selected national value-for-money studies, using indicators based on the original study recommendations.*



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## Introduction

1. In 1997/98, 66,000 people in England and Wales were treated in hospital for hip fracture. This number had risen from 60,000 in 1995/96 – an increase of 5 per cent per year. Three-quarters of those affected were aged over 75, and 80 per cent were women.
2. Care of hip fracture patients is a good indicator of the quality of hospital services for elderly people in general because:
  - their care needs are often complex, requiring a wide range of hospital services; and
  - recovery, post-fracture, can be improved if services are well-planned and co-ordinated from the time that patients first enter hospital, through to their discharge.
3. The Audit Commission's report, *United They Stand: Co-ordinating Care for Elderly Patients with Hip Fracture*, published in 1995, recommended that:
  - patients should be assessed immediately in accident and emergency (A&E);
  - they should then be admitted to a ward without any further delay;
  - operations should be carried out, or supervised, by a specialist registrar or consultant;
  - physicians who specialise in elderly care should be involved in the care of hip fracture patients; and
  - patients should be rehabilitated as soon as possible.
4. This update examines the changes that have since taken place with respect to each of these recommendations. It is based on a survey carried out by the Audit Commission in England and Wales in early 1999, in which 139 trusts out of 199 (70 per cent) participated by collecting data on a sample of their patients. Of these 139 trusts, 10 were in Wales; they showed generally better performance in A&E than trusts in England, but otherwise their performance was very similar.<sup>1</sup>

*A fast-track protocol for patients with hip fracture has been introduced by 75 per cent of A&E departments*

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<sup>1</sup> All references and charts refer to England and Wales combined unless otherwise stated.

## Waiting for assessment in A&E

5. Patients arriving in A&E with suspected hip fracture are vulnerable to pressure sores and dehydration. It is important that they should spend the shortest possible time in A&E and be admitted to a ward where they can receive appropriate treatment. The Royal College of Physicians has recommended that 'Managers and clinicians should ensure that patients spend no more than one hour in A&E'. However, the update survey found that very few trusts are achieving this objective. Only 7 per cent of patients overall are admitted within one hour and the average wait<sup>I</sup> is 2.8 hours. Only three A&E departments reported an average wait of less than one hour [EXHIBIT 1].

6. A fast-track protocol<sup>II</sup> for patients with hip fracture has been introduced by 75 per cent of A&E departments. These departments achieved an average wait of 2.6 hours, substantially shorter than the 3.4 hours for those that lack such a protocol.

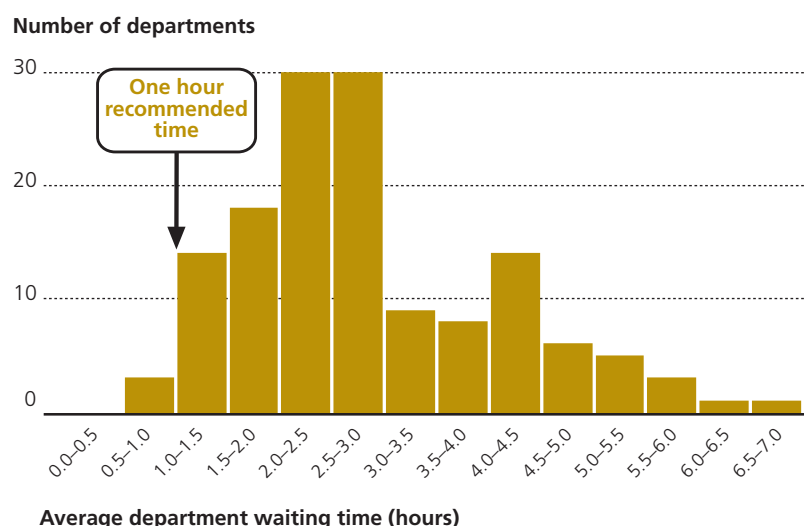
I All 'averages' for waiting times in A&E are based on the medians for each department to avoid possible distortion by a few very high figures.

II A process that allows patients with hip fracture to get priority for the necessary assessment procedures in A&E, such as X-rays.

EXHIBIT 1

### Average waiting times in A&E departments, 1999

Most departments have average waiting times that are longer than the one hour recommended.



Source: Audit Commission survey

7. Most departments with a fast-track protocol have also set a target for patient waiting times in A&E. These range from half an hour to four hours, but in two-thirds of departments the target is set at one hour. However, very few of those departments that have set a one-hour target are achieving it; the average wait reported was 2.5 hours. Targets that are so widely missed are of little value. Trusts should analyse the performance of their A&E departments, set realistic targets and implement effective means of achieving them.

8. Overall, average waiting times in A&E departments have not changed since the original report. Some departments report improved performance, but an equal number report lengthened waiting times [EXHIBIT 2].

9. Average waiting times for patients in A&E do not reveal the range of delays that patients actually experience. In the best performing department, a maximum wait of 1.7 hours was achieved. However, one-quarter of departments recorded delays of more than eight hours for some patients [EXHIBIT 3].

10. Welsh A&E departments achieved better performance; their average wait was only 1.7 hours compared with 2.8 hours in English A&E departments. Furthermore, they showed widespread improvement since the original audit [EXHIBIT 4].

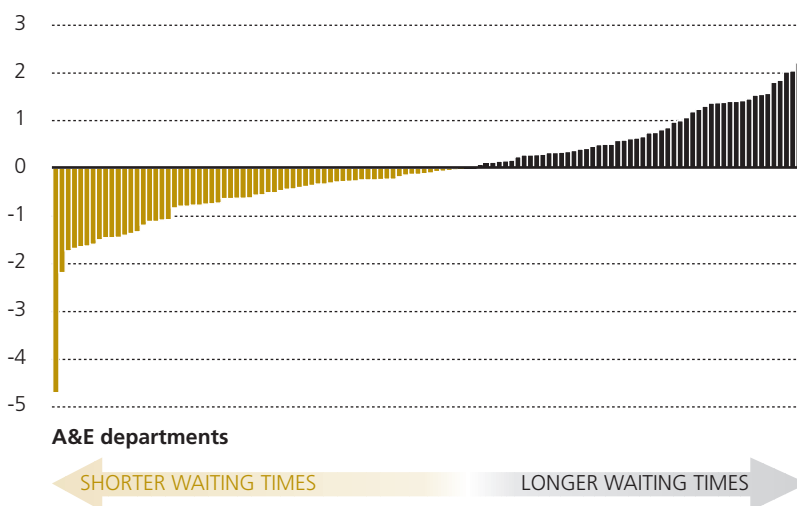
11. Maximum waiting times in Welsh A&E departments also tend to be shorter than those in England; the longest wait reported was 5.5 hours [EXHIBIT 5].

EXHIBIT 2

**Change in average waiting times in A&E, 1995-1999**

Some departments have reduced waiting times in A&E but, in others, patients have to wait longer now than they did in 1995.

**Change in average waiting time (hours)**



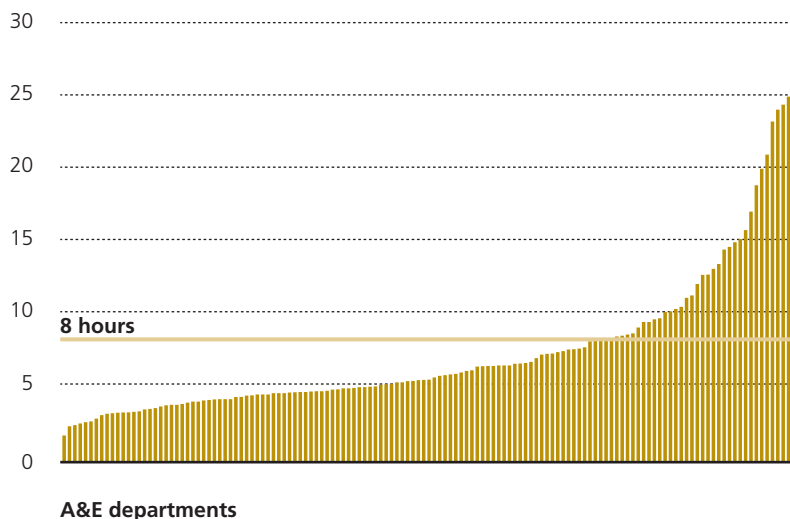
Source: Audit Commission survey

EXHIBIT 3

**Maximum waiting times in A&E departments**

In one-quarter of departments, some patients waited eight hours or more in A&E.

**Maximum waiting time (hours)**



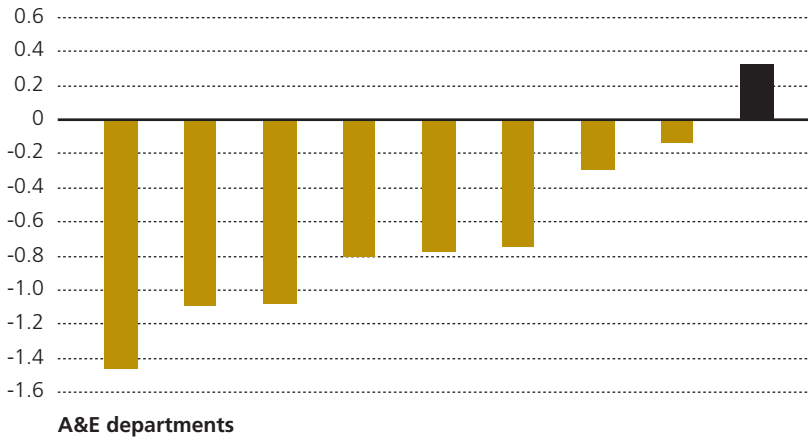
Source: Audit Commission survey

EXHIBIT 4

**Change in average waiting times in A&E departments in Wales, 1995-1999**

All but one of the Welsh departments surveyed have achieved improvements in their waiting times in A&E since 1995.

**Change in average waiting time (hours)**



Source: Audit Commission survey

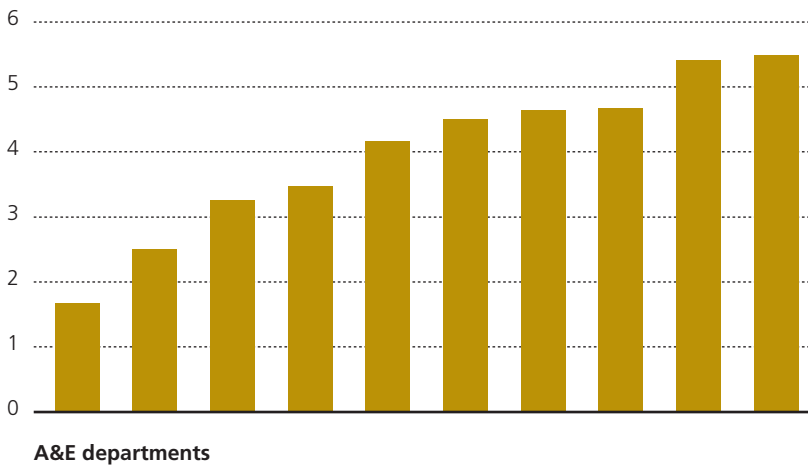
*One-quarter of departments recorded delays of more than eight hours for some patients*

EXHIBIT 5

**Maximum waiting times in Welsh A&E departments**

Maximum waiting times in Wales tend to be shorter than those in England.

**Maximum waiting time (hours)**



Source: Audit Commission survey

# Waiting times for operations

**12.** The Royal College of Physicians recommends that, for patients with hip fracture, ‘operations should be carried out within 24 hours, by senior staff’. On average, one-half of patients waited more than 24 hours. This performance has not improved since 1995.

**13.** Patients who wait more than 48 hours for their operation are more likely to die subsequently<sup>1</sup>.

The best performing trusts reported that all patients with hip fracture had their operations within 48 hours. But, in 27 per cent of trusts more than one-quarter of patients waited for more than 48 hours, although some of this waiting period may have been due to postponements because patients were unfit. Trusts that have a significant percentage of patients waiting for longer than 48 hours should review their performance to identify both the reasons for delay and the consequences. They should then strive to remedy the causes of delay.

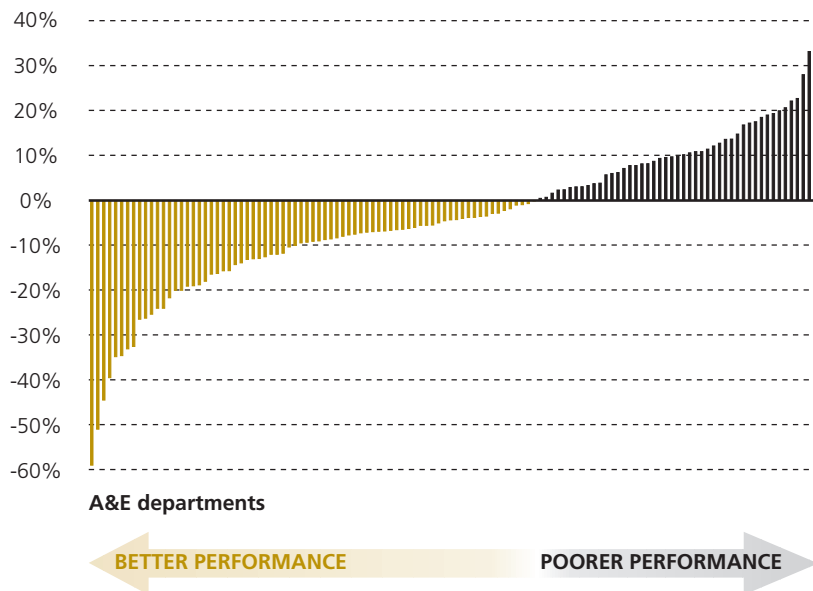
**14.** Since 1995, slightly more than one-half of trusts have been able to reduce the time that patients wait for their operations but, in the rest, performance has deteriorated [EXHIBIT 6]. Overall, 22 per cent of patients waited more than 48 hours in 1995, a proportion that had been reduced to 18 per cent in 1999.

EXHIBIT 6

## Change in percentage of patients waiting over 48 hours for their operations, 1995-1999

There has been improvement in just over one-half of the trusts, but deterioration in the remainder.

### Change



Source: Audit Commission survey

<sup>1</sup> C J Todd et al, 'Differences in mortality after fracture of hip: The East Anglian audit', *British Medical Journal*, Vol. 310, 1995.

15. The British Orthopaedic Association recommends that trusts should introduce daily trauma lists<sup>1</sup> to help to reduce the waiting times for operations. However, 17 per cent of trusts still do not use trauma lists and, of those that do, less than one-half continue the lists at weekends.

16. Cancelling operations is particularly risky for elderly patients, since repeated starvation prior to anaesthesia can lead to dehydration and nutritional problems, and increase the likelihood of complications and poor recovery. To minimise distress and improve outcomes, cancellation rates should, therefore, be kept to a minimum. However, 43 per cent of the trusts surveyed cancelled operations for reasons that they regarded as

unacceptable, such as lack of theatre staff. For most, the numbers were small, but a few trusts cancelled more than 20 per cent of their operations for unacceptable reasons [EXHIBIT 7].

*Cancelling operations is particularly risky for elderly patients*

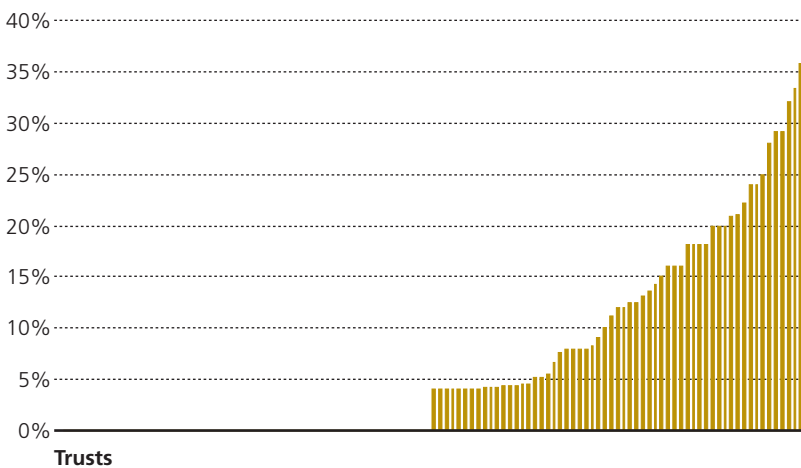
<sup>1</sup> A 'trauma list' is a theatre session that is dedicated to treating serious injuries such as hip fracture.

EXHIBIT 7

**Percentage of operations cancelled for unacceptable reasons, 1999**

Eleven per cent of trusts cancelled 20 per cent or more of their hip fracture operations for reasons that they regarded as unacceptable.

**Percentage of operations**



# Grade of doctors carrying out operations

17. The Royal College of Physicians recommends that hip fracture operations should be carried out by experienced doctors. If either the surgeon or the anaesthetist is only a senior house officer (SHO), he or she should be supervised by a specialist registrar or consultant in the same specialty. In our follow-up survey, only a few trusts reported that some of their operations were carried out by unsupervised SHO surgeons. However, for anaesthetists the position was much less favourable, with about one-half of the trusts reporting occasions where the anaesthetic was administered by an unsupervised SHO [EXHIBIT 8]. Nevertheless, this represents an

improvement since the original audit. The overall proportion of operations carried out by unsupervised SHO surgeons has fallen from 9 per cent to 1 per cent. For anaesthetists, the equivalent figures are 30 per cent falling to 11 per cent.

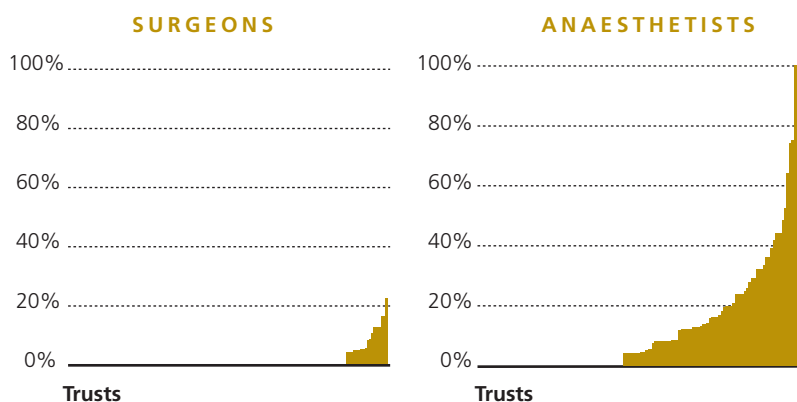
18. Although the frequency of operations carried out by unsupervised SHOs has diminished, the recently published report on deaths within 30 days of surgery<sup>1</sup> expressed concern at the increasing proportion of operations undertaken by non-consultant career grades (NCCGs). These are hospital doctors who are not on a formal training programme to become a consultant. The NCEPOD report commented that such doctors have varying degrees of experience and that 27 per cent of the surgeons in this category did not possess a qualification higher than that required to be registered as a doctor. We found that the proportion of hip fracture operations carried out in trusts by NCCG surgeons ranged from zero to 95 per cent, with an overall average of 26 per cent.

EXHIBIT 8

## Operations carried out by unsupervised SHOs, 1999 – surgeons compared with anaesthetists

Only a few operations are still carried out by unsupervised SHO surgeons, but for anaesthetists there is much more room for improvement.

Percentage of operations carried out by unsupervised SHOs



Note: Many trusts reported zero operations carried out by unsupervised SHOs.

Source: Audit Commission survey

1 NCEPOD, *Extremes of age: The 1999 Report of the National Confidential Enquiry into Perioperative Deaths*, London, NCEPOD, 1999.

## Involving physicians in patient care

**19.** The original report pointed out that many patients have medical problems in addition to their hip fracture, and would benefit if physicians worked alongside the orthopaedic surgeons. One measure that indicates the extent of such liaison is joint ward rounds between orthopaedic surgeons and physicians, but only 23 per cent of trusts have adopted this practice.

**20.** Patients with hip fracture are vulnerable to pressure sores, and adequate preventive advice is required from a specialist nurse. Sixty per cent of trusts now employ specialist nurses with responsibility for evaluating the risk of pressure sores and advising on prevention.

*Only 23 per cent of trusts have adopted the practice of joint ward rounds between orthopaedic surgeons and physicians*

# Rehabilitation

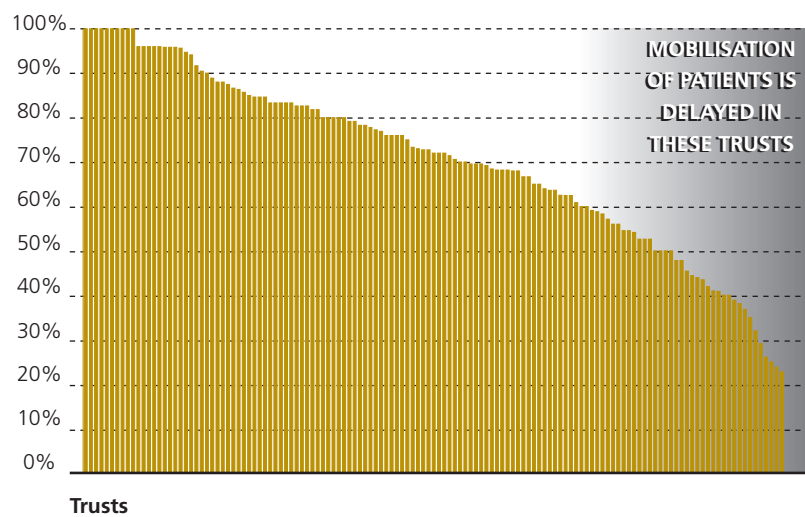
21. Early mobilisation<sup>1</sup> of patients after their operation promotes their confidence and reduces the risk of complications. In half the trusts surveyed, 71 per cent or more of patients were mobilised within 48 hours. However, a small minority (7 per cent) of trusts were mobilising less than 40 per cent of patients within 48 hours [EXHIBIT 9]. Overall, 29 per cent of patients are not mobilised within 48 hours.

EXHIBIT 9

## Percentage of hip fracture patients mobilised within 48 hours of their operations, 1999

There is wide variation between trusts in the percentage of patients who are mobilised within 48 hours of their operation.

### Percentage of patients mobilised within 48 hours



<sup>1</sup> Defined as getting out of bed, helped either by a nurse or a physiotherapist.

Source: Audit Commission survey

## The next steps

**22.** Some trusts have achieved improvements in the key areas, but in many cases performance has either not improved or has deteriorated. In these trusts, a complete process redesign is needed to ensure a smooth flow of patients along the desired care path that will improve both patients' experiences and clinical outcomes.

**23.** Trusts should consult their auditors to find out how they compare with other similar trusts and where the greatest improvements in their performance are needed. Realistic but challenging targets should be set and performance against them regularly monitored.

## Following up value-for-money studies and audits

Each year the Audit Commission follows up selected national studies and associated local audits that it has carried out to see what changes have taken place. It does this by identifying key indicators – value-for-money indicators (VFMI) – which are based on the recommendations made by the study. New data for these indicators are compared against the data collected at the time of the original audit. The choice of studies depends on the continued relevance of the topic and recommendations, and the scope for change. The results provide not only a valuable national picture of change, but also allow individual trusts to gauge their own progress against that of other, similar trusts. Separate results are produced by auditors for each individual trust using computer software that allows them to select indicators and tailor comparative groups to particular local needs. The information for hip fracture treatment has recently been given to auditors, and chief executives should discuss the mechanisms for local feedback with their auditor if they have not already done so.

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*Further copies and copies of the national report on which this update is based, United They Stand: Co-ordinating Care for Elderly Patients with Hip Fracture (ISBN 0118864343, 1995, £10) are available from:*

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