	Appraisal of quality of indicator for provisional CCG OIS
Indicator ref.: IND-22	**Indicator title:** Hip Fracture Care Process Composite Indicator
Key considerations for the NICE Committee	• This measure is established at provider level within the National Hip Fracture Database and is reported in their annual report. It is linked to the Best Practice Tariff (BPT) for hip fracture care. • A number of respondents to the stakeholder engagement felt that this indicator would lead to service improvements, however one commented that it isn't really an outcome measure, • **Summary: the HSCIC view is that this indicator is feasible.**
Rationale	This indicator is based on the NICE Quality Standard 16: Hip fracture in adults, issued March 2012 http://guidance.nice.org.uk/QS16. To ensure good quality care for people with hip fracture it is important that all aspects of the care pathway are delivered. There is evidence to suggest that in some cases individual care process are delivered but not others. This indicator provides CCGs with an indication of care provision across a whole pathway of care.
What is measured	**Source of data** National Hip Fracture Database (NHFD). **Denominator** The number of patients in the National Hip Fracture Database who have been discharged. **Numerator** Of the denominator, the number who receive all nine of the agreed Best Practice Tariff standards. The nine agreed Best Practice Tariff standards (as per 2013-14 BPT guidance) are as follows: • Time to surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an admitted patient, to the start of anaesthesia; • Admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon; • Admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia; • Assessed by a geriatrician in the perioperative period (within 72 hours of admission); • Post-operative geriatrician-directed multi-professional rehabilitation team; • Fracture prevention assessments (falls and bone health); • Abbreviated Mental Test performed prior to surgery and score recorded in NHFD. • Abbreviated Mental Test performed post-surgery and score recorded in NHFD. • Orthogeriatrician GMC and surgeon GMC number are present. All nine fields in the NHFD are populated with valid data to satisfy the numerator.

Suitability of indicator for purpose	**Data Quality dimensions:** **Completeness** Since 2007, NHFD coverage has expanded steadily, with all 163 eligible hospitals in England, now registered to participate in this optional audit (186 in England, Wales and Northern Ireland). 'Eligible' indicates that they provide a comprehensive hip fracture service for a local population. **Accuracy** 100% of the eligible hospitals regularly upload case records in a standard dataset format that covers casemix, care and outcomes. Hospitals receive benchmarked feedback that enables clinicians and managers to monitor and improve the care they provide. **Timeliness** The underlying data required for the construction of the indicator are available on an annual basis. Data from the NHFD for the full year (2015/2016) is expected to be available for publication in September 2016, subject to a Data Sharing Agreement with HQIP. **Accessibility** The underlying data are held by the NHFD and published in the annual audit report. **Relevance** This could be used by CCGs to assess the level of service provision that they commission as it contributes to the quality of outcome for the patient.
How data are aggregated	The indicator will be reported as a percentage, disaggregated by Clinical Commissioning Group. Confidence intervals will be calculated using the Wilson Score method, as specified in 'Commonly used public health statistics and their confidence intervals' (Association of Public Health Observatories, March 2008).
Risk adjustment	It is not recommended to standardise or risk adjust this indicator, as all hip fracture patients should receive the 9 BPT standards.
Scientific validity	The sample data used in this report shows provider level figures taken from the 2013 NHFD National Report. Data from the NHFD can be aggregated at CCG level, for example as in CCG OIS indicators 3.12 (Hip fracture: timely surgery) and 3.13 (Hip fracture: multifactorial falls risk assessment). There may be local variation in data quality, particularly diagnostic and procedure coding.
Interpretation	A high percentage of hip fracture patients receiving all nine BPT standards is desirable. This indicator should be taken in conjunction with other indicators and information from other sources to form a holistic view of CCG outcomes and give a fuller overview of how CCG processes are impacting on outcomes.
Equality	The proposed indicator may show some geographic variation, although this may be due to a

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<tr><td>assessment</td><td>number of reasons including social factors such as deprivation and/or ethnicity. Further examination of the underlying data may show other variations which may need to be taken into account when developing the indicator.

The following fields are available in NHFD which would support analysis by the following equality dimensions:
Age
Gender</td></tr>
<tr><td>Use, follow-up investigation and action</td><td>The data could be analysed by the equality dimensions to investigate if there are specific issues within certain groups. HSCIC will assess the options for this analysis as part of further development and checking for data quality issues. CCGs could also undertake local analysis.</td></tr>
<tr><td>Feedback from HSCIC consultation</td><td>
<table>
<tr><th>Question</th><th>N</th><th colspan="5">Response (%)</th></tr>
<tr><td>Organisation</td><td>10</td><td colspan="5">General Practice (10%), Royal College (10%), Other (10%), Clinical Commissioning Group (30%), Acute Trust (40%)</td></tr>
<tr><td></td><td></td><td>Strongly Agree</td><td>Agree</td><td>Disagree</td><td>Strongly Disagree</td><td>Don't Know</td></tr>
<tr><td>Well defined</td><td>9</td><td>55.6%</td><td>33.3%</td><td>11.1%</td><td>0.0%</td><td>0.0%</td></tr>
<tr><td>Well-constructed</td><td>9</td><td>55.6%</td><td>22.2%</td><td>11.1%</td><td>0.0%</td><td>11.1%</td></tr>
<tr><td></td><td></td><td>Yes, significant issues</td><td>Yes, minor issues</td><td>No Issues</td><td>Don't Know</td><td></td></tr>
<tr><td>Data Quality issues</td><td>9</td><td>22.2%</td><td>44.4%</td><td>22.2%</td><td>11.1%</td><td></td></tr>
<tr><td></td><td></td><td>Highly likely</td><td>Quite likely</td><td>Quite unlikely</td><td>Highly unlikely</td><td>Don’t know</td></tr>
<tr><td>Likely service improvements</td><td>9</td><td>22.2%</td><td>44.4%</td><td>11.1%</td><td>0.0%</td><td>22.2%</td></tr>
<tr><td>Results group dependant</td><td>9</td><td>33.3%</td><td>0.0%</td><td>22.2%</td><td>11.1%</td><td>33.3%</td></tr>
<tr><td>Likely perverse incentives</td><td>9</td><td>0.0%</td><td>22.2%</td><td>44.4%</td><td>11.1%</td><td>22.2%</td></tr>
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If you do not agree that the indicator is clearly defined and unambiguous please describe how you think the definition could be improved

I can only remember 8 standards from the DOH and 6 from the NHFD.
Given NICE mandate a DXA in those with a hip fracture aged under 75, it is almost punitive to use the count the numbers discharged on bone medication as those waiting for a DXA (best evidenced care) are grouped with those missed. What qualifies as a bone or falls assessment is unclear. To reduce re-fracture need to adhere to therapy and that needs to be included, e.g. number still receiving prescription of bone agents at 3 and 12 months. Why are there no falls treatments endpoints, e.g. completion of Otago programme? Need to have marker of discharged home as a percentage of those admitted from home. No feel for those discharged for palliative care or care home where secondary prevention is not appropriate.

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	If you do not agree that the indicator is suitably constructed please describe how you think the construction could be improved • By only counting the number discharged, a unit with poor hospital care, high inpatient mortality, will be missed. If you expect that there will be data quality issues associated with this indicator please provide more detail as to what you think these might be • Inaccuracies in data collection at individual trust level. Some indicators such require calculations of the number of hours during the patient's admission can be difficult to be accurate. • Subjectivity of scoring for one or two BPT areas remains a limitation - e.g. in definition of 'Falls Assessment'. • There are likely to be delays in the reporting of the data. • There is little consistency as to how the follow up assessments are made nor what constitutes a bone or falls assessment. If you think that it is unlikely that service changes can be implemented as a result of the reporting generated by this indicator please explain why • Existing financial pressure to achieve BPT means that many units are already achieving near maximal scores on this - so the indicator is not particularly challenging. • Will only change if more focus is given to post discharge care. If you would expect to see different results for particular groups please describe what differences you would expect to see and for which groups • Elderly people with poor health. They are more likely to survive after breaking their hips. • Not an issue: Hip fracture incidence is not affected by socioeconomic deprivation, and the majority of people sustaining this fracture are to some extent disabled prior to their injury... as a result hip fracture care tends to be very egalitarian. • Poorer metrics for those with cognitive impairment. If you think that it is likely perverse incentives may occur please explain what kinds of issues you think may arise • If there is a focus on time to surgery, queue jumping may occur. • The preferential treatment for hip fracture patients may lead to poorer care for patients with other types of fractures. The lack of resources allocated for trauma at individual trusts level may mean more delay to treatment for other types of patients. In Major Trauma Centres, life and limb threatening injuries need to be treated immediately and this can compromise the Centres' ability to fast track hip fracture patients to meet the 36hours to surgery target. This can perversely penalise Centres of excellence whilst smaller centres which do not deal with major trauma victims can manage the hip fracture pathways much better. • This is using existing data which is already routinely collected - and existing financial incentives are greater than any associated with CCG OIS. Do you have any other views or general feedback that you would like to provide about this indicator? • Best practice indicators in hip fractures have revolutionised the way we treat this

	group of patients. We have seen peri-operative mortally rates drop significantly. However, the same approach needs to be transferred to other areas of trauma care. A strong socio-economic case can be made that prompt, high quality trauma management will save the society financially by reducing disability, improving productivity and reduction on social care bills, in the long term. • I'm concerned about the availability of data sets for these new indicators. We have had the CCGOIS in place for a year now but still most of the data sets are either unavailable or have a long time lag. This causes anxiety in the system if it is thought we are being measured against something but cannot monitor it as there is no data set to support it. Please don't select any indicators unless data is readily available to monitor them. • Please include more information on long term adherence to bone and falls therapies. • The BPT standards are of course a surrogate for good quality care. What we really need are patient outcomes - embedded in the NHFD - this would be a real driver to improve care.

Sample data - This sample data shows provider level figures for this indicator as published in the 2013 NHFD National Report (Chart 33 BPT Achievement, p56 http://www.nhfd.co.uk).