

Hip fracture in adults

NICE quality standard

March 2012

August 2016

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). It does not cover the prevention of hip fracture, which is covered by NICE quality standards for [osteoporosis](#), [falls: prevention](#) and [falls in older people](#).

For more information see the [hip fracture topic overview](#).

This quality standard has been updated. The topic was identified for update following the annual review of quality standards in 2015. The review identified that there had been changes in the areas for improvement for hip fracture. For further information about the update, including statements from the 2012 quality standard that are no longer national priorities for improvement but are still underpinned by current accredited guidance, see [update information](#).

Why this quality standard is needed

Hip fractures occur in the area between the edge of the femoral head and 5 cm below the lesser trochanter. These fractures are generally divided into two main groups. Those above the insertion of the capsule of the hip joint are called intracapsular, subcapital or femoral neck fractures. Those below the insertion are extracapsular.

Hip fracture is a major health issue in an ageing population. About 70,000 to 75,000 hip fractures occur each year and the annual cost (including medical and social care) for all UK hip fracture cases is about £2 billion. Demographic projections indicate that the UK annual incidence will rise to 101,000 in 2020, with an associated increase in

annual expenditure. The majority of this expenditure will be accounted for by hospital bed days and a further substantial contribution will come from health and social aftercare. About 25% of people with hip fracture are admitted from institutional care, and about 10–20% of those admitted from home ultimately move to institutional care. About 10% of people with a hip fracture die within 1 month and about one-third within 12 months. Most of the deaths are due to associated conditions and not to the fracture itself, reflecting the high prevalence of comorbidity. Although hip fracture occurs predominantly in later life (the [National Hip Fracture Database](#) reports the average age of a person with hip fracture as 84 years for men and 83 for women), it may occur at any age, especially in people with osteoporosis or osteopenia.

Because a fall and resulting hip fracture often signals underlying ill health, a comprehensive multidisciplinary approach is needed from presentation to follow-up, including the transition from hospital to the community. Management of hip fracture has improved, especially with the collaboration of teams specialising in the care of older people ('orthogeriatrics'). These skills apply to hip fracture in adults, irrespective of age.

The quality standard is expected to contribute to improvements in the following outcomes:

- length of hospital stay
- readmission to hospital
- reoperation rates
- mortality rates.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – safety, experience and effectiveness of care – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 3 outcomes frameworks published by the Department of Health:

- [NHS Outcomes Framework 2016–17](#)
- [Adult Social Care Outcomes Framework 2015–16](#)
- [Public health outcomes framework for England, 2016–2019.](#)

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 [NHS Outcomes Framework 2016–17](#)

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	<p>Overarching indicators</p> <p>1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare</p> <p>i Adults</p> <p>1b Life expectancy at 75</p> <p>i Males ii Females</p>
3 Helping people to recover from episodes of ill health or following injury	<p>Overarching indicators</p> <p>3b Emergency readmissions within 30 days of discharge from hospital*</p> <p>Improvement areas</p> <p>Improving outcomes from planned treatments</p> <p>3.1 Total health gain as assessed by patients for elective procedures</p> <p><i>i Physical health-related procedures</i></p> <p>Improving recovery from injuries and trauma</p> <p>3.3 <i>Survival from major trauma</i></p> <p>Improving recovery from fragility fractures</p> <p>3.5 Proportion of patients recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days</p> <p>Helping older people to recover their independence after illness or injury</p> <p>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*</p> <p>ii Proportion offered rehabilitation following discharge from acute or community hospital</p>

<p>4 Ensuring that people have a positive experience of care</p>	<p>Overarching indicators 4b Patient experience of hospital care 4c <i>Friends and family test</i> 4d <i>Patient experience characterised as poor or worse</i> ii <i>Hospital care</i></p> <p>Improvement areas Improving people’s experience of outpatient care 4.1 Patient experience of outpatient services Improving hospitals’ responsiveness to personal needs 4.2 Responsiveness to inpatients’ personal needs Improving people’s experience of accident and emergency services 4.3 Patient experience of A&E services</p>
<p>5 Treating and caring for people in a safe environment and protecting them from avoidable harm</p>	<p>Overarching indicators 5a <i>Deaths attributable to problems in healthcare</i> 5b <i>Severe harm attributable to problems in healthcare</i></p> <p>Improvement areas Reducing the incidence of avoidable harm 5.3 <i>Proportion of patients with category 2, 3 and 4 pressure ulcers</i> 5.4 <i>Hip fractures from falls during hospital care</i> Improving the culture of safety reporting 5.6 Patient safety incidents reported</p>
<p>Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared Indicators in italics in development</p>	

Table 2 [The Adult Social Care Outcomes Framework 2015–16](#)

Domain	Overarching and outcome measures
<p>2 Delaying and reducing the need for care and support</p>	<p>Overarching measure 2A Permanent admissions to residential and nursing care homes, per 100,000 population</p> <p>Outcome measures Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services 2B Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services*</p>

	<p>2D The outcomes of short-term services: sequel to service <i>Placeholder 2E The effectiveness of reablement services</i></p> <p>When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence</p> <p>2C Delayed transfers of care from hospital, and those which are attributable to adult social care</p>
<p>Alignment with NHS Outcomes Framework and/or Public Health Outcomes Framework</p> <p>* Indicator is shared</p> <p>Indicators in italics in development</p>	

Table 3 [Public health outcomes framework for England, 2013–16](#)

Domain	Objectives and indicators
4 Healthcare public health and preventing premature mortality	<p>Objective</p> <p>Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities</p> <p>Indicators</p> <p>4.11 Emergency readmissions within 30 days of discharge from hospital*</p> <p>4.13 Health-related quality of life for older people</p> <p>4.14 Hip fractures in people aged 65 and over</p>
<p>Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework</p> <p>* Indicator is shared</p>	

Safety and people’s experience of care

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to hip fracture.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services (see the NICE pathway on [patient experience in adult NHS services](#)), which should be considered alongside this quality standard.

They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. They also cover the provision of information to people using services. Quality statements on these aspects of patient

experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that affect people's experience of using services and are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for hip fracture specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole hip fracture care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to adults with hip fracture in secondary care.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality.

Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality hip fracture service are listed in [related quality standards](#).

Quality standards should be achievable by local services given the resources required to implement them. Resource impact considerations are taken into account by the quality standards advisory committee, drawing on resource impact work associated with source guidelines. The costing statements for the source guidelines provide more detailed resource impact information. Organisations are encouraged to use these tools to help estimate local costs.

- [Costing report](#) for NICE guideline CG124 (Hip fracture: management)

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare practitioners involved in assessing, caring for and treating people with hip fracture should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually

included in quality standards. However, recommendations in the development source(s) on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting people with hip fracture in secondary care. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

[Statement 1](#). Adults with hip fracture are cared for within a Hip Fracture Programme, which includes clinical and service governance responsibility for all stages of the care pathway. **[2012, updated 2016]**

[Statement 2](#). Adults with hip fracture have surgery on a planned trauma list on the day of, or the day after, admission. **[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 trochanteric fractures above and including the lesser trochanter receive extramedullary implants. **[2012, updated 2016]**

[Statement 5](#). Adults with subtrochanteric fracture are treated with intramedullary nail. **[new 2016]**

[Statement 6](#). Adults with hip fracture start mobilisation at least once a day, no later than the day after surgery. **[2012, updated 2016]**

Quality statement 1: Multidisciplinary management

Quality statement

Adults with hip fracture are cared for within a Hip Fracture Programme, which includes clinical and service governance responsibility for all stages of the care pathway. [2012, updated 2016]

Rationale

People with hip fracture, including those cared for in the community, often have comorbidities and complex care needs. The multidisciplinary approach of a 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. The clinical and service governance responsibility of the Hip Fracture Programme can help to improve quality by ensuring hospitals are held responsible for continuously improving care regardless of the department, Trust or organisation providing care.

Quality measures

Structure

a) Evidence of local arrangements to ensure that people with hip fracture are cared for within a Hip Fracture Programme, which includes clinical governance responsibility of all stages of the care pathway.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that people with hip fracture are cared for within a Hip Fracture Programme, which includes service governance responsibility of all stages of the care pathway.

Data source: Local data collection.

Process

a) Proportion of presentations of hip fracture in which the person receives an orthogeriatric assessment.

Numerator – the number in the denominator in which the person receives an orthogeriatric assessment.

Denominator – the number of presentations of hip fracture.

Data source: Local data collection. The [National Hip Fracture Database](#) records access to orthogeriatric assessment.

b) Proportion of presentations of hip fracture in which the person has early identification of their goals for multidisciplinary rehabilitation.

Numerator – the number in the denominator in which the person has early identification of their goals for multidisciplinary rehabilitation.

Denominator – the number of presentations of hip fracture.

Data source: Local data collection. The [National Hip Fracture Database](#) records multidisciplinary team meetings.

c) Proportion of presentations of hip fracture in which the person has orthogeriatric and multidisciplinary review.

Numerator – the number in the denominator in which the person has orthogeriatric and multidisciplinary review.

Denominator – the number of presentations of hip fracture.

Data source: Local data collection. The [National Hip Fracture Database](#) records access to orthogeriatric assessment and multidisciplinary team meetings.

d) Proportion of presentations of hip fracture in which the person is discharged from hospital to intermediate care under the responsibility of the Hip Fracture Programme.

Numerator – the number in the denominator in which the person is under the responsibility of the Hip Fracture Programme.

Denominator – the number of presentations of hip fracture discharged to intermediate care.

Data source: Local data collection.

Outcome

a) Hospital length of stay for people with hip fracture.

Data source: Local data collection.

b) Hospital readmissions for people with hip fracture within 30 days.

Data source: Local data collection.

c) Mortality for people with hip fracture within 120 days.

Data source: Local data collection.

d) Return to the pre-hip fracture place of residence.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (such as hospitals) have systems in place to ensure that people with hip fracture are cared for within a Hip Fracture Programme, which includes clinical and service governance responsibility for all stages of the care pathway.

Healthcare professionals (such as orthogeriatricians, nurses and social workers) care for people with hip fracture using a Hip Fracture Programme, which includes clinical and service governance responsibility for all stages of the care pathway.

Commissioners (such as clinical commissioning groups and NHS England) ensure that they commission hip fracture services that provide care within a Hip Fracture Programme, which includes clinical and service governance responsibility for all stages of the care pathway.

What the quality statement means for patients and carers

People with hip fracture are looked after as part of a programme of care, called a Hip Fracture Programme. This involves a team of healthcare professionals with different skills working together to provide care. Hip Fracture Programmes include

regular assessment, and coordination of care and rehabilitation in hospital and after discharge.

Source guidance

- [Hip fracture: management](#) (2011) NICE guideline CG124, recommendations 1.8.1 (key priority for implementation).

Definitions of terms used in this quality statement

Hip Fracture Programme

A coordinated multidisciplinary approach ensuring continuity of care and responsibility across the clinical pathway covering care in all settings, including ambulances, A&E, radiology, operating theatres, wards and in the community and primary care, and at all stages, including diagnosis, treatment, recovery, discharge planning, rehabilitation, long-term after care and secondary prevention.

Formal 'orthogeriatric' care, with the geriatric medical team contributing to joint preoperative patient assessment, and increasingly taking the lead in postoperative medical care, multidisciplinary rehabilitation and discharge planning. It includes all of the following:

- orthogeriatric assessment
- rapid optimisation of fitness for surgery
- early identification of individual goals for multidisciplinary rehabilitation to recover mobility and independence, and to facilitate return to pre-fracture residence and long-term wellbeing
- continued, coordinated, orthogeriatric and multidisciplinary review
- liaison or integration with related services, particularly mental health, falls prevention, bone health, primary care and social services
- clinical and service governance responsibility for all stages of the pathway of care and rehabilitation, including those delivered in the community.

[\[Hip fracture\]](#) (NICE full guideline CG124)

Quality statement 2: Timing and expertise for surgery

Quality statement

Adults with hip fracture have surgery on a planned trauma list on the day of, or the day after, admission. [2012, updated 2016]

Rationale

People with hip fracture can experience pain and anxiety while waiting for an operation. Delays in surgery are associated with negative outcomes for mortality, length of hospital stay and return to mobility. Therefore, it is important to avoid any unnecessary delays for people who are assessed fit for surgery. A planned trauma list includes specific healthcare professionals with the expertise required for hip surgery. Senior staff supervision can help to reduce the risk of complications during the surgery.

Quality measures

Structure

a) Evidence of local arrangements to ensure that people with hip fracture have surgery on a planned trauma list.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that people with hip fracture have surgery on the day of, or the day after, admission.

Data source: Local data collection.

Process

a) Proportion of operations for hip fracture that are performed on a planned trauma list.

Numerator – the number in the denominator that are performed on a planned trauma list.

Denominator – the number of operations for hip fracture.

Data source: Local data collection. The [National Hip Fracture Database](#) records the time of the operation.

b) Proportion of operations for hip fracture that are performed on the day of, or the day after, admission.

Numerator – the number in the denominator that are performed on the day of, or the day after, admission.

Denominator – the number of operations for hip fracture.

Data source: Local data collection. The Health and Social Care Information Centre's [Compendium of Clinical and Health Indicators](#) records emergency hospital admissions and timely surgery: fractured proximal femur. The [National Hip Fracture Database](#) records the time of the operation.

Outcome

a) Postoperative complications for people with hip fracture.

Data source: Local data collection.

b) Postoperative delirium for people with hip fracture.

Data source: Local data collection and the [National Hip Fracture Database](#).

c) Length of hospital stay for people with hip fracture.

Data source: Local data collection.

d) Mortality of people with hip fracture.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (hospitals) ensure that systems are in place for people with hip fracture to have surgery on a planned trauma list on the day of, or the day after, admission.

Healthcare professionals (such as specialists, orthogeriatricians and anaesthetists) perform hip fracture surgery on a planned trauma list on the day of, or the day after, admission.

Commissioners (such as clinical commissioning groups and NHS England) ensure that they commission services that have sufficient capacity for people with hip fracture to have surgery on a planned trauma list on the day of, or the day after, admission.

What the quality statement means for patients and carers

People admitted to hospital with hip fracture have an operation carried out by a team of senior specialists on the day they are admitted or the next day.

Source guidance

- [Hip fracture: management](#) (2011) NICE guideline CG124, recommendations 1.2.1 (key priority for implementation) and 1.5.1.

Definitions of terms used in this quality statement

Planned trauma list

A planned trauma list is one with a rostered senior anaesthetist, senior surgeon and dedicated theatre time. [[Hip fracture](#) (NICE full guideline CG124)]

Quality statement 3: Intracapsular fracture

Quality statement

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]

Rationale

Cemented arthroplasty is a preferred option for adults with displaced intracapsular fracture because it can result in less pain and reduced need for surgical revision than other options. It is usually carried out by hemiarthroplasty, but may also be carried out by total hip replacement in people who are clinically eligible for the procedure. Total hip replacement may prevent the need for further surgery in the future. This saves the discomfort and risks associated with additional surgery as well as the cost for the health service.

Quality measures

Structure

Evidence of local arrangements to ensure that people with displaced intracapsular fracture receive cemented arthroplasty, and those who are assessed as clinically eligible are offered total hip replacement.

Data source: Local data collection.

Process

a) Proportion of presentations of displaced intracapsular fracture for which the person receives cemented arthroplasty.

Numerator – the number in the denominator for which the person receives cemented arthroplasty.

Denominator – the number of presentations of displaced intracapsular fracture.

Data source: Local data collection. The [National Hip Fracture Database](#) records procedure type for intracapsular displaced fracture and cementing of arthroplasties.

b) Proportion of presentations of displaced intracapsular fracture for which the person receives total hip replacement if they are assessed as clinically eligible.

Numerator – the number in the denominator for which the person receives total hip replacement.

Denominator – the number of presentations of displaced intracapsular fractures in which the person is eligible for total hip replacement.

Data source: Local data collection. The [National Hip Fracture Database](#) records procedure type for intracapsular displaced fracture and cementing of arthroplasties.

Outcome

Number of people with hip fracture receiving re-operation of the hip.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (hospitals) ensure that systems are in place for people with displaced intracapsular fracture to receive cemented arthroplasty, and for those who are assessed as clinically eligible to be offered a total hip replacement.

Healthcare professionals (orthopaedic surgeons) ensure that people with displaced intracapsular fracture receive cemented arthroplasty, and those who are assessed as clinically eligible are offered a total hip replacement.

Commissioners (such as clinical commissioning groups and NHS England) ensure that they commission services in which people with displaced intracapsular fracture receive cemented arthroplasty, and those who are assessed as clinically eligible are offered a total hip replacement.

What the quality statement means for patients and carers

People admitted to hospital with a fracture inside the socket of their hip joint and where the bones have moved out of position (called a displaced intracapsular fracture) have an operation to replace the broken part of the hip joint

(the 'ball' of the joint) with an artificial part. However, some people are offered a total hip replacement operation to replace both parts of the hip joint (the ball and socket) with artificial parts. This is a bigger operation and only people who were fit and active before the fracture who are assessed as well enough to have the operation are offered this.

Source guidance

- [Hip fracture: management](#) (2011) NICE guideline CG124, recommendations 1.6.2, 1.6.3 (key priorities for implementation) and 1.6.5.

Definitions of terms used in this quality statement

Intracapsular fractures

Fractures above the insertion of the capsular attachment of the hip joint are called intracapsular. [[Hip fracture](#) (NICE full guideline CG124)]

Cemented arthroplasty

Surgical procedure for hip replacement that involves the use of cement to fill the gaps between the metal prosthesis and the bone. [[Hip fracture](#) (NICE full guideline CG124)]

Clinically eligible

Total hip replacements should be offered to patients with a displaced intracapsular fracture who:

- were able to walk independently out of doors with no more than the use of a stick **and**
- are not cognitively impaired **and**
- are medically fit for anaesthesia and the procedure.

[[Hip fracture: management](#) (NICE guideline CG124) recommendation 1.6.3]

Equality and diversity considerations

Healthcare professionals should be aware that some people with hip fracture may have additional needs in understanding the information given to them which can

affect whether they choose total hip replacement. This includes people with learning disabilities and those who are not fluent in English.

Quality statement 4: Trochanteric fracture

Quality statement

Adults with trochanteric fractures above and including the lesser trochanter receive extramedullary implants. [2012, updated 2016]

Rationale

Extramedullary implants, such as sliding hip screws, have similar clinical outcomes to intramedullary devices. However, some studies have shown that intramedullary implants have a higher reoperation rate because of periprosthetic fracture. In addition, extramedullary implants are less expensive so they are recommended for the treatment of trochanteric fractures.

Quality measures

Structure

Evidence of local arrangements to ensure that people with trochanteric fractures above and including the lesser trochanter receive extramedullary implants.

Data source: Local data collection.

Process

Proportion of presentations of trochanteric fractures above and including the lesser trochanter for which the person receives extramedullary implants.

Numerator – the number in the denominator for which the person receives extramedullary implants.

Denominator – the number of presentations of trochanteric fractures above and including the lesser trochanter.

Data source: Local data collection. The [National Hip Fracture Database](#) records procedure type for trochanteric fracture.

Outcome

Re-operation rates for people with trochanteric fractures.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (such as hospitals) ensure that systems are in place for people with trochanteric fractures above and including the lesser trochanter to receive extramedullary implants in preference to an intramedullary nail.

Healthcare professionals (specialists and orthopaedic surgeons) ensure that people with trochanteric fractures above and including the lesser trochanter receive extramedullary implants in preference to an intramedullary nail.

Commissioners (such as clinical commissioning groups and NHS England) ensure that they commission services where people with trochanteric fractures above and including the lesser trochanter receive extramedullary implants in preference to an intramedullary nail.

What the quality statement means for patients and carers

People admitted to hospital with a fracture outside the socket of their hip joint and near the top of the thigh bone (called a trochanteric fracture) have an operation to reposition the broken bone and hold it in place while it heals. This is done using one or more special screws inserted into the bone and attached to a metal plate.

Source guidance

- [Hip fracture: management](#) (2011) NICE guideline CG124, recommendation 1.6.7 (key priorities for implementation).

Definitions of terms used in this quality statement

Trochanteric fractures

Fractures which occur outside or distal to the hip joint capsule and can be two-part fractures (stable) or multi-fragmentary (unstable). [[Hip fracture](#) (NICE full guideline CG124)]

Extramedullary implants

A screw that is attached to a plate on the outside of the femoral head and neck. [[Hip fracture](#) (NICE full guideline CG124)]

Quality statement 5: Subtrochanteric fracture

Quality statement

Adults with subtrochanteric fracture are treated with an intramedullary nail. [new 2016]

Rationale

Subtrochanteric fractures may occur as a result of a pathological process in the bone. This pre-existing pathology may not always be recognised on the initial radiographs. Using an intramedullary device can provide mechanical protection to a potentially diseased bone. Intramedullary fixation is the treatment of choice for subtrochanteric fractures because it allows splinting of the whole of the femoral shaft. Although intramedullary nails are more expensive than extramedullary implants, they lead to fewer patients with non-union of fracture needing reoperation.

Quality measures

Structure

Evidence of local arrangements to ensure that people with subtrochanteric fracture are treated with an intramedullary nail.

Data source: Local data collection.

Process

Proportion of presentations of subtrochanteric fractures treated with an intramedullary nail.

Numerator – the number in the denominator that are treated with an intramedullary nail.

Denominator – the number of presentations of subtrochanteric fractures.

Data source: Local data collection.

Outcome

a) Number of people with non-union of fracture.

Data source: Local data collection.

b) Re-operation rates for people with subtrochanteric fractures.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (such as hospitals) ensure that systems are in place for people with subtrochanteric fractures to be treated with an intramedullary nail.

Healthcare professionals (orthopaedic surgeons) perform surgery on people with subtrochanteric fractures using an intramedullary nail.

Commissioners (such as clinical commissioning groups and NHS England) ensure that they commission services where people with subtrochanteric fractures are treated with an intramedullary nail.

What the quality statement means for patients and carers

People admitted to hospital with a fracture outside the socket of their hip joint and a small way down the thigh bone (called a subtrochanteric fracture) have an operation to reposition the broken bone and hold it in place while it heals. This is done using a metal rod, called an intramedullary nail, which is inserted into the bone.

Source guidance

- [Hip fracture: management](#) (2011) NICE guideline CG124, recommendation 1.6.8.

Definitions of terms used in this quality statement

Subtrochanteric fracture

The fracture is predominantly in the 5 cm of bone immediately distal to the lesser trochanter. [[Hip fracture](#) (NICE full guideline CG124)]

Intramedullary nail

A metal rod, which is inserted down the middle of the femoral shaft. [[Hip fracture](#) (NICE full guideline CG124)]

Quality statement 6: Mobilisation after surgery

Quality statement

Adults with hip fracture start mobilisation at least once a day, no later than the day after surgery. [2012, updated 2016]

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. Mobilisation involves a physiotherapist assessment to inform the development of their rehabilitation plan. People should be offered support with mobilisation at least every day while in hospital, which can be given by the nursing team when the physiotherapist is not present. This support should continue after discharge from hospital.

Quality measures

Structure

Evidence of local arrangements to ensure that people with hip fracture start mobilisation at least once a day, no later than the day after surgery.

Data source: Local data collection.

Process

a) Proportion of hip fracture operations in which the person starts mobilisation no later than the day after surgery.

Numerator – the number in the denominator in which the person starts mobilisation no later than the day after surgery.

Denominator – the number of hip fracture operations.

Data source: Local data collection.

b) Proportion of hip fracture operations following which the person has mobilisation at least once a day during their hospital stay.

Numerator – the number in the denominator following which the person has mobilisation at least once a day during their hospital stay.

Denominator – the number of hip fracture operations.

Data source: Local data collection.

Outcome

a) Length of hospital stay for people with hip fracture.

Data source: Local data collection.

b) Return to the pre-hip fracture place of residence.

Data source: Local data collection.

c) Return to the pre-hip fracture level of mobility.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (such as hospitals) ensure that systems are in place for people with hip fracture to start mobilisation at least once a day, no later than the day after surgery.

Healthcare professionals (such as physiotherapists and nurses) ensure that they offer people with hip fracture mobilisation at least once a day, starting no later than the day after surgery.

Commissioners (such as clinical commissioning groups and NHS England) ensure that they commission services in which people with hip fracture start mobilisation at least once a day, no later than the day after surgery.

What the quality statement means for patients, and carers

People who have had an operation to treat a hip fracture are offered support to mobilise at least once a day, starting no later than the day after their operation

(unless there is a medical or surgical reason not to). The mobilisation is to improve movement, strength and help with their recovery.

Source guidance

- [Hip fracture: management](#) (2011) NICE guideline CG124, recommendations 1.7.1 and 1.7.2.

Definitions of terms used in this quality statement

Mobilisation

Mobilisation is the process of rehabilitating the patient. It re-establishes the ability to move between postures (for example to stand, transfer practice, balance work and strengthening exercises), maintain an upright posture and to ambulate with increasing levels of complexity (speed, changes of direction, dual and multi-tasking). [[Hip fracture](#) (NICE full guideline CG124) and expert consensus]

Equality and diversity considerations

Healthcare professionals should be aware that some people with hip fracture may have additional needs in understanding the information given to them, which can determine whether they fully understand the purpose of early mobilisation. This includes adults with learning disabilities, cognitive impairment and those who are not fluent in English.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's [What makes up a NICE quality standard?](#) for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

NICE's [quality standard service improvement template](#) helps providers to make an initial assessment of their service compared with a selection of quality statements. It includes assessing current practice, recording an action plan and monitoring quality improvement.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in [development sources](#)

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and [equality assessments](#) are available.

Good communication between health, public health and social care practitioners and people with hip fracture is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People with hip fracture in hospital should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the quality standards [process guide](#).

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- [Hip fracture: management](#) (2011) NICE guideline CG124

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Royal College of Physicians (2015) [Secondary fracture prevention: first steps to a national audit](#)
- [Hip fracture](#) [QS16] (2015) NICE uptake data

Definitions and data sources for the quality measures

- Health and Social Care Information Centre [Compendium of Clinical and Health Indicators](#)
- Royal College of Physicians (2015) [National Hip Fracture Database \(NHFD\) annual report 2015](#)

Related NICE quality standards

Published

- [Falls in older people](#) (2015) NICE quality standard 86
- [Delirium in adults](#) (2014) NICE quality standard 63

In development

- [Falls: prevention](#). Publication expected January 2017
- [Osteoporosis](#). Publication expected April 2017

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Falls: regaining independence for older people who experience a fall
- Regaining independence (Reablement): short term interventions to help people to regain independence

The full list of quality standard topics referred to NICE is available from the [quality standards topic library](#) on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 4. Membership of this committee is as follows:

Miss Alison Allam

Lay member

Dr Harry Allen

Consultant Old Age Psychiatrist, Manchester Mental Health and Social Care Trust

Mrs Moyra Amess

Associate Director, Assurance and Accreditation, CASPE Health Knowledge Systems

Mrs Jane Bradshaw

Neurology Nurse Consultant, Nationwide

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Chair, Liverpool Clinical Commissioning Group

Mr Tim Fielding

Consultant in Public Health, North Lincolnshire Council

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Network Manager, South Wales Critical Care Network

Ms Nicola Hobbs

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Mr Roger Hughes

Lay member

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Chief Executive Officer, Healthcare Quality Improvement Partnership

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Independent Patient Safety Nurse, Palladium Patient Safety

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GP Principal, Oakfield Health Centre, Kent

Mr Alaster Rutherford

Primary Care Pharmacist, NHS Bath and North East Somerset

Mr Michael Varrow

Information and Intelligence Business Partner, Essex County Council

Mr David Weaver

Head of Quality and Safety, North Kent Clinical Commissioning Group

The following specialist members joined the committee to develop this quality standard:

Mr Tim Chesser

Consultant Trauma and Orthopaedic Surgeon, North Bristol NHS Trust

Miss Ruth Halliday

Trauma and Orthopaedic Research Physiotherapist, North Bristol NHS Trust

Dr Antony Johansen

Consultant Orthogeriatrician, Cardiff and Vale University Health Board

Dr Iain Moppett

Associate Professor and Consultant Anaesthetist, University of Nottingham

Professor Cameron Swift

Emeritus Professor of Health Care of the Elderly, Kings College London School of Medicine

Mrs Jan Wright

Matron, Musculoskeletal Services, Ipswich Hospital NHS Trust

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Programme Manager

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About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the [quality standards process guide](#).

This quality standard has been incorporated into the NICE pathway on [hip fracture](#).

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Update information

In 2016, this quality standard was updated and statements prioritised in 2012 were replaced.

Statements marked as **[new 2016]** because they cover a new area for quality improvement.

Statements are marked as **[2012, updated 2016]** because the statement covers an area for quality improvement included in the 2012 quality standard and has been updated.

Statements numbered 1, 2, 5, 6, 7, 8 and 9 in the 2012 version have been updated and included in the updated quality standard, marked as **[2012, updated 2016]**.

The statements below from the 2012 version (numbered 1, 3, 4, 10, 11 and 12) are no longer considered national priorities for improvement but may still be useful at a local level:

- People with hip fracture have their cognitive status assessed, measured and recorded from admission.
- People with hip fracture receive prompt and effective pain management, in a manner that takes into account the hierarchy of pain management drugs, throughout their hospital stay.
- People with hip fracture are offered early supported discharge (if they are eligible), led by the Hip Fracture Programme team.
- People with hip fracture are offered a multifactorial risk assessment to identify and address future falls risk, and are offered individualised intervention if appropriate.
- People with hip fracture are offered a bone health assessment to identify future fracture risk and offered pharmacological intervention as needed before discharge from hospital.

A pdf version of the 2012 quality standard is available [here](#).

ISBN: