



**Case study: Improving mortality figures
North Hampshire Hospital, Hampshire
Toby Briant-Evans, Consultant T&O Surgeon**

Background

The 2018 NHFD annual report reported that mortality for hip fracture patients in North Hampshire Hospital had risen to 11.5% in 2017, meaning we had been identified as an official outlier for 30 day mortality. We believed that the causes for our high mortality rates were multifactorial, but that key contributing factors were a lack of orthogeriatric support, a decline in nursing staffing levels, a high non-operative rate, lack of adherence to a standardised anaesthetic protocol and delays in mobilising patients post op. We also identified that we had been underscoring ASA grades and overscoring pre-injury mobility, which would have had a negative effect on our casemix adjustment.

Aim

Our key priority was reducing the mortality rate. The overall aim was to address each of the issues raised above (and more) which should lead to improvements in overall patient care and therefore our patient mortality.

Process

All members of the multidisciplinary team (MDT) looking after our hip fracture patients were involved in working to delivering an improved service. A core working group of representatives from all parts of the MDT was established and attended a monthly meeting. The Trust board and executive team were engaged and gave their support to the action plan. The neck of femur (NOF) service was officially re-launched at a half day MDT event involving the entire department, covering all aspects of NOF care.

At the monthly NOF MDT meetings, NHFD runcharts were reviewed and any deaths from the previous month were reviewed with learning points disseminated to the wider team. The NHFD runcharts were also displayed in the trauma meeting room for all staff to see and we ensured these were updated monthly.

In addition to the above, two formal reviews of the NOF service were carried out. The first was internal which included a full audit of all deaths over a 14 month period; which was then followed by an external British Orthopaedic Association (BOA) review. We visited a neighbouring Trust who had been through similar issues and who had seen major improvements. A 70 point action plan was then formulated from the recommendations from both reports which was divided into immediate 'easy wins', medium (3 month) and long term (>6 month) plans; which were then allocated to a nominated representative for each speciality within the MDT.

Multiple initiatives were introduced during our reviews of the NOF service. Probably the key factor was a culture change within the department, with NOFs becoming the priority within the trauma service and buy in from all members of the MDT and Trust senior management.

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Outcomes

The results from this work have exceeded our expectations, with our mortality falling from 11.4% to 4.8% over 16 months. We also found improvements reached beyond just reducing mortality rates: our non-operative rate has also reduced from 6.3% to 1.7%, day 1 mobilisation has improved from 63% to 88%, reoperation rate has dropped from 3.2% to 0.4%, and anaesthetic nerve block rate has risen from 12% to 71%. A new Orthogeriatric Consultant has been appointed, together with a supporting team of middle grades and nurse practitioners. A recruitment drive for nursing staff has been successful and overall morale in the service has risen.

Getting buy in from the whole team and a change in culture was crucial to our success. A combination of lots of small, achievable steps can result in significant gains. An external BOA review is particularly useful in objectively assessing the service and lends weight in raising issues to senior management. Learning from experiences of other units is also key, many units have been in this situation themselves before and the underlying issues are often similar such that strategies to deal with problems are often generic to all units and can be widely applied to outlier hospitals.