Royal College of Physicians

Falls and Fragility Fracture Audit Programme (FFFAP)

Recovering after a hip fracture: helping people understand physiotherapy in the NHS

Physiotherapy 'hip sprint' audit report 2017

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British Orthopaedic Association 1918–2018 Caring for Patients : Supporting Surgeons

BGS British Geriatrics Society Improving healthcare for older people

National Osteoporosis Society

Public Health England

HQIP Healthcare Quality Improvement Partnership

Chartered Society of Physiotherapy

Recovering after a hip fracture: helping people understand physiotherapy in the NHS. Physiotherapy 'Hip Sprint' audit report 2017

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PHFSA data collection webtool and **www.nhfd.co.uk** are provided by Crown Informatics **www.crowninformatics.com**

Falls and Fragility Fracture Audit Programme
The National Hip Fracture Database (NHFD) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and managed by the Royal College of Physicians (RCP) as part of the Falls and Fragility Fracture Audit Programme (FFFAP) alongside the Fracture Liaison Service Database (FLS-DB) and Falls Pathway workstream. FFFAP aims to improve the delivery of care for patients having falls or sustaining fractures through effective measurement against standards and feedback to providers.

Chartered Society of Physiotherapy
The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for the UK's 57,000 chartered physiotherapists, physiotherapy students and support workers.

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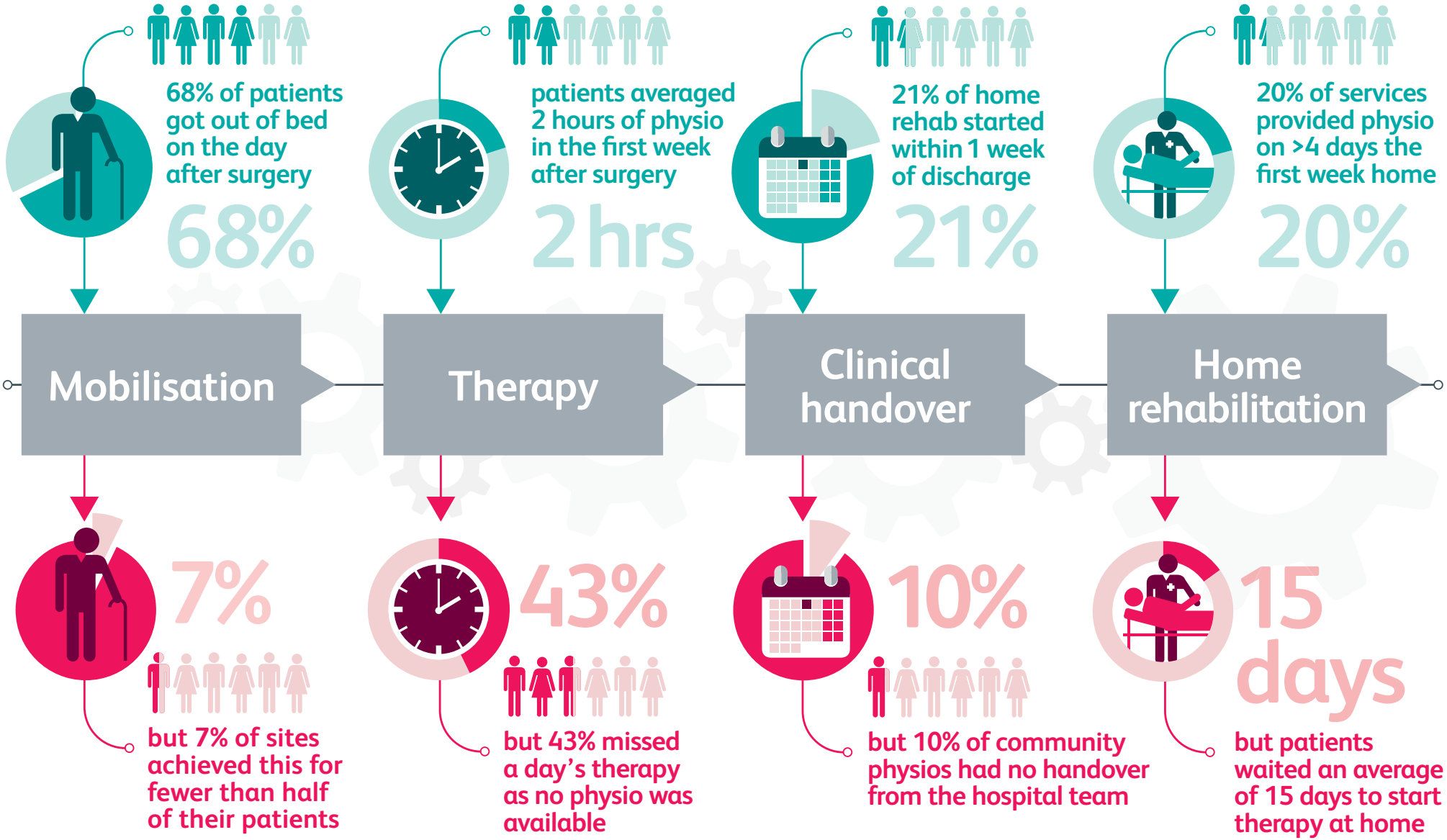
Hospital to home

Findings of the Hip Sprint audit



'My mother's story'

'My mother' – Alice Price

My mother, Alice Price, was in her eighties at the time of her hip fracture.

After a successful operation, she uncharacteristically failed to engage with the staff and patients on the ward and just slept a great deal – postoperative delirium was eventually diagnosed.

As a result, she was unable to stand or take a few steps unaided, buy it was her inability to engage with medical, nursing and physiotherapy staff caused her rehabilitation to stop.

She found the busy acute ward distressing. Unfortunately, at the time, appropriate community hospitals with rehabilitation facilities were full, and it was decided to discharge my mother to a nursing home, and to start her rehabilitation with the community team when the delirium passed.

Following the move to the nursing home, she quickly emerged from the delirium – the calmer, quieter environment suited her. She was now ready and keen to restart her rehabilitation.

I had expected 'joined-up' care for someone after hip fracture, but found that this doesn't always happen. I was stunned to discover that the GP was not able to put her back into the rehabilitation system where she had left it. She was processed as a 'new referral' to the community team.

It took 4 months for her to be assessed by them. She became depressed during this waiting period – dependence upon others for her every need was very difficult for such an independent woman.

Physiotherapy started soon after her assessment. She worked hard and, after a short period, was able to stand and take a few steps with a walking frame. She was thrilled and her depression began to lift.

Unfortunately, she contracted a chest infection and died shortly after finally starting physiotherapy.

I am left wondering how different her emotional state could have been for her last months had she received rehabilitation as soon as she was capable of undertaking it.

My mother needed rehabilitation, but due to the delirium and the initial delay in her recovery, the appropriate timely 'rehabilitation pathway' just wasn't there for her.

We must make sure that all patients have the best possible chance of making as good a recovery as they are capable of – however long that may take, or wherever they may be in the system.

Iona Price, January 2018

Iona Price is now deputy chair of the Falls and Fragility Fracture Audit Programme board

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Introduction

Hip fracture is a serious, life-changing injury that can affect older people, and is the commonest reason for them to need emergency anaesthesia and surgery. The people who suffer this injury are typically in their eighties, with one or more pre-existing medical or psychiatric conditions, but modern anaesthesia and surgery are now so successful that nearly all patients have prompt and effective repair of their injury, and most are able to get out of bed by the day after surgery.

However, recovery from this injury serves as an excellent example of the challenges faced by frail and older patients, and by the multidisciplinary teams (MDTs) who seek to restore them to their previous mobility, independence and quality of life.

For this reason, the National Hip Fracture Database (NHFD) and the Chartered Society of Physiotherapy (CSP) collaborated in this 'Hip Sprint' audit in 2017.

National Hip Fracture Database (NHFD)

The NHFD is managed by the Royal College of Physicians (RCP) as part of its Falls and Fragility Fracture Audit Programme (FFFAP), alongside the Fracture Liaison Service Database (FLS-DB) and the National Audit of Inpatient Falls (NAIF). These national clinical audits aim to improve the delivery of care for patients having falls or sustaining fractures through effective measurement against standards and feedback to providers. In 2017, a total of 173 acute hospitals in England and Wales were routinely contributing data to the NHFD.

'Hip Sprint'

In early 2017 a data set was created by key stakeholders and clinical specialists in hip fracture to review physiotherapy rehabilitation for hip fracture patients in the UK. This data set was mapped, where possible, to the National Institute for Health and Care Excellence (NICE) recommendations in clinical guideline 124 (CG124).

In May–October 2017, the CSP led work to recruit over 580 physiotherapists caring for nearly 7,000 people who were admitted with hip fracture to 131/173 applicable acute hospitals.

Four acute hospitals were excluded from our analysis as they provided data on less than 10 patients, and as such, data could not be relied upon as being representative of local services. This meant that Hip Sprint was able to use data for 5,989 (78.6%) of the 7,621 people who the NHFD recorded as presenting to these 127 hospitals between May and June 2017.

The people whose care is described in this report were completely typical of those who commonly suffer hip fracture (Table 1). Most were in their eighties, and over two-thirds were women. Four out

of five people were living in their own home before the hip fracture. One-third were able to walk freely without a walking stick, but one-quarter were housebound or living in a care home, and one-third had a pre-existing memory problem.

	NHFD	Hip Sprint
Number of patients	7,821	5,989
Number of acute hospitals	172	127
Mean age (years)	82.6	82.8
Women (%)	70.9	71.6
Living at home (%)	81.5	81.6
Freely mobile with no aids before hip fracture (%)	35.7	35.8
Housebound before hip fracture (%)	25.2	25.8
Cognitive impairment before hip fracture (% AMT<8)	33.6	34

Table 1 Patients admitted with a new hip fracture in England and Wales during May and June 2017

Key findings and recommendations

Key findings

Hip Sprint is the biggest ever audit of UK physiotherapy, and has implications for physiotherapists working in many settings. Hip fracture is an ideal tracer condition with which to examine the quality and intensity of the therapy that any frail or older person might expect to receive if they are admitted to hospital with an illness that suddenly deprives them of their mobility and independence.

If patients are to recover from events such as a hip fracture, frail or older people will need continued multidisciplinary rehabilitation, with personalised therapy that follows their needs and is not disrupted as they move away from the acute ward.

Key findings and recommendations, where possible, were mapped to NICE guidance (CG124).

Acute care

- 68.4% of patients were mobilised out of bed on the day following their surgery, but there is significant variation in performance, and nine hospitals (7.1%) achieved this for fewer than half of their patients.
- Nearly one in ten patients (9.4%) were unable to get up on the day after their operation as a result of pain or low blood pressure – factors that might have been anticipated by clear perioperative protocols and closer working between surgical and anaesthetic colleagues.
- Routine SMART (specific, measurable, achievable, realistic, time-based) rehabilitation planning was carried out for six out of seven patients (83.6%), but Hip Sprint found major variation around the country, with this being done for nearly all patients in 41 hospitals, but not done at all in seven hospitals.

- On average, each patient received 2 hours of physiotherapy (118 minutes) in the first week after their operation. From just under half an hour (27 minutes) of therapy on the day after surgery, this reduced gradually over the rest of the week.
- On average, the first week of a patient's therapy utilised over 3.5 hours of staff time – about 2 hours of physiotherapist time, with the rest provided by physiotherapy assistants or other ward staff. These figures varied hugely around the country, with less than 1 hour in some units but several hours in others.
- Two in five (42.9%) people missed a day's therapy because of problems with physiotherapist availability – staffing problems resulted in a failure to deliver the National Institute for Health and Care Excellence (NICE) recommendation for daily rehabilitation.
- At the weekend, patients were significantly less likely to get up on the day after surgery – only 63% did so successfully, compared with 75% on weekdays. Day 1 therapy sessions on Saturday and Sunday lasted for 79% as long and involved only 75% of the staff time, when compared to those provided during the working week.
- In over one-third (37.0%) of units, therapists did not attend monthly clinical governance meetings with the other members of the Hip Fracture Programme's MDT.

Next step (rehabilitation ward)

- Over half of people moved to another ward or hospital, or were discharged home, within 2 weeks of their admission with a hip fracture.
- Care pathways are complex and vary to an enormous degree nationally.
- Rehabilitation goals had been agreed for six out of seven patients, but this approach varied considerably between hospitals; it was routine for everyone in many settings, but not done at all in five hospitals.
- The total staff time involved in providing therapy remained very similar to that in acute wards, but since patients had improved by this stage they needed fewer staff and managed longer therapy sessions – an additional half an hour each week.

Home rehabilitation

- One in five services (26/127) maintained the continuity of rehabilitation – averaging no more than 1 week between discharge and the start of therapy in a patient's home. On average patients waited 15.2 days, and in five units more than 1 month, to start therapy at home.
- On average, in the first week after discharge nearly two hours of staff time was invested in therapy – around half the time that was being provided while they were inpatients.
- Physio and physio-assistant time each accounted for nearly three quarters of an hour of this total, with just over 20 minutes provided by occupational therapists, nurses and other staff.

- Most patients received therapy on more than one day, but Hip Sprint identified twelve community rehabilitation services that reported providing therapy on more than 4 days of the first week of their involvement with patients.

- In keeping with NICE guidance, most community rehabilitation services surveyed by Hip Sprint (88.2%) reported that they were able to provide therapy to people who returned to live in a care home, but it would be useful for Hip Sprint follow-up work to consider the extent to which rehabilitation is actually provided to this specific group of frailest patients.

- One in ten community services told us that they received no patient handover from hospital teams. This made Hip Sprint data collection difficult in many services, and suggests that the needs of individual patients were not being communicated between therapists or teams.

Recommendations

Early mobilisation

- Collaborative multidisciplinary working is needed to ensure that pain, hypotension and delirium do not hold back early progress in physiotherapy.

- Patients should be helped to get up by the day after surgery – such 'mobilisation' is key to patients' wellbeing and avoidance of complications such as delirium, deconditioning and pressure damage. This mobilisation is just one element of the physiotherapy provided to patients, but it is the key measure that the NHFD will use to drive forward local quality improvement after Hip Sprint.

- Local therapy teams should review how they record patients' progress, so that there is clear communication of patient outcomes to MDT colleagues and correct reporting to the NHFD.

Intensive rehabilitation

- Hip fracture programmes should invest in early intensive rehabilitation to maximise the number of people who can be discharged directly home from the acute orthopaedic ward.

- Hospital physiotherapy teams should put in place systems to ensure that more intense rehabilitation includes attention to strength, balance and endurance, as well as mobility.

- Physiotherapists should consider how they are teaching and working with colleagues, as Hip Sprint found little evidence that therapy work is being delegated to other staff; a missed opportunity for multidisciplinary working.

Continuity of care

- Commissioners should consider a whole-pathway approach to rehabilitation over the months that most people will take to reach their full potential.

- NICE recommended that hip fracture programmes should have responsibility for all stages of the pathway of care and rehabilitation, and therapists should ensure that their patients are able to continue uninterrupted rehabilitation when they return to their own homes.

- Local referral structures between hospital services and community therapy teams should be reviewed to ensure that these are suitable for handover of the personal needs of individual patients.

Local governance and quality improvement

- Physiotherapists, surgeons, anaesthetists, orthogeriatricians and nurses should all attend monthly hip fracture programme clinical governance meetings.

- Physiotherapists, surgeons, anaesthetists, orthogeriatricians and nurses should review their own unit's Hip Sprint data at www.nhfd.co.uk and agree on a local quality improvement action plan.

- Staffing levels affect patient care, especially after the first postoperative day and at weekends, and physiotherapists should continue the transparent approach developed in Hip Sprint to highlight concerns if staffing limits their ability to deliver care as per NICE recommendations.

1 Acute care

Ideally, hip fracture surgery will mean that a patient's hip joint can move comfortably enough for them to sit up, sit on the side of the bed and then stand or be helped out into a chair by the day after surgery.

Being able to do this is a hugely positive step in recovery and means that people avoid the discomfort, indignity and risks of having to be nursed in bed.

The frailest people with hip fracture, and particularly the one-third who have memory problems, are at particular risk of 'deconditioning' (losing the ability to cope with activities such as walking and caring for themselves) if they get out of their normal routine, lose muscle strength and suffer complications of bed rest such as infections or pressure sores.

National Institute for Health and Care Excellence – CG124 (2011)

Offer all patients a hip fracture programme that includes 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
- communication with the primary care team
- clinical and service governance responsibility for all stages of the pathway of care and rehabilitation.

Postoperative mobilisation

Modern anaesthesia and hip fracture surgery are now so successful that most people are able to get out of bed by the day after surgery. However, everyone is an individual and their personal medical, psychological and social circumstances may affect how rapidly they respond to the care of nurses and therapists in the days and weeks that follow.

Some types of hip fracture are more complicated than others, and some people have more trouble with bruising after their operation and may be unable to get up without additional pain relief. Others may lose more blood at the time of surgery or have medical problems that mean their blood pressure is low afterwards, and may need attention before they can stand without feeling faint.

Around a quarter of people, especially those with pre-existing memory problems, become muddled, agitated or sleepy with 'delirium' in the period after surgery. Other people are simply frightened by the prospect of getting up so soon after their fall. As a result of these factors, a number of people are unable to get up by the day after their operation.

> **National Institute for Health and Care Excellence QS16 (2016)**
>
> Statement 6. Adults with hip fracture start rehabilitation at least once a day, no later than the day after surgery.

Mobilisation by the first day after surgery

Hip Sprint asked therapists to report how many patients were able to get out of bed by being helped to stand or being hoisted out of bed by the day following their operation.

Physiotherapists in 127 hospitals provided data on 5,989 acute patients, representing 78.6% of all patients admitted to those hospitals in May and June 2017.

In total, 68.4% of all patients managed to get out of bed by the day after their operation.

Hip Sprint found significant variation in performance against this indicator, with four hospitals able to provide this level of rehabilitation for fewer than half of their hip fracture patients.

This is slightly lower than the figure of 77% that hospitals routinely report to the NHFD, suggesting that the NHFD figure may have been inflated. Clarity in the definition of mobilisation is a key issue if the NHFD is to continue to support and monitor local performance and help drive quality improvement through investment in perioperative care and rehabilitation.

The NHFD asks whether 'patients were able to get out of bed by being helped to stand or being hoisted out of bed by the day following their operation', a definition that is helpfully, though perhaps unattractively, summed up as 'bum off bed'.

Physiotherapists in every hospital need to consider how they are interpreting this point, and how they are recording local success and failure in delivering it, so that this information is reliable and readily available to the staff who collect and enter it into the NHFD.

The impact of physiotherapist assessment

Hip Sprint found that 39/40 patients were assessed by a physiotherapist on the day after surgery. However this means that one in 40 patients (2.7%) were not assessed and as a result did not get up that day. This was unusual in most units, but a significant problem in a limited number of hospitals.

Ten hospitals reported that over one in ten patients did not receive physiotherapist-led assessment and did not manage to get up by the day after surgery.

Other factors limiting early mobilisation

Physiotherapists were asked to identify why some patients were not able to be transferred (standing or hoisted) out of bed on the day after their operation.

As per figure 1 patient refusal and agitation was the most commonly recorded specific reason followed by pain control and low blood pressure. 'Other' contraindications were recorded for one in ten patients.

As a result, nearly one-third of people were unable to get up by the day after their operation. However, different hospitals varied enormously in how well they achieved this first rehabilitation goal. Figures for individual hospitals can be viewed at **www.fffap.org.uk/phfsa**.

Nearly one in ten people did not get up as a result of pain, or hypotension or a combination of both – constraints that are predictable consequences of hip fracture surgery and that could be targeted for multidisciplinary intervention before the physiotherapist sees them. In the best units, the MDT of medical, nursing and therapy staff will have developed routines that anticipate all of these problems and so reduce the likelihood of patients needing to remain in bed.

It is very unusual for people to get up on the same day as their operation. However high-quality postoperative surgical and anaesthetic communication could make this possible for some patients who have surgery in the morning; this did take place on occasion in 35% of units.

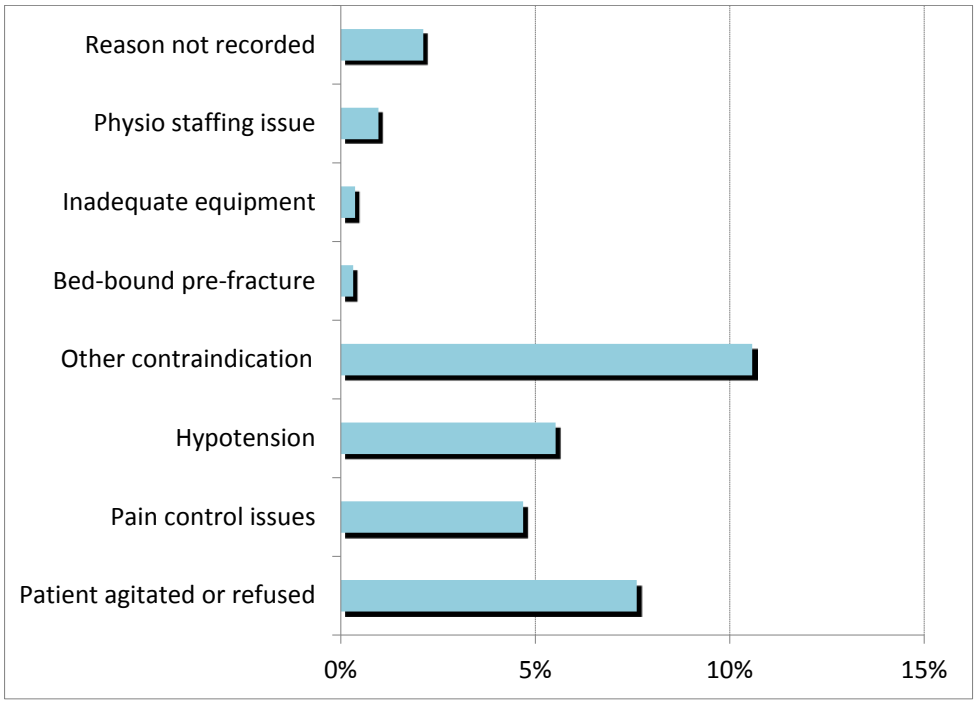

Figure 1 Reasons for failure to mobilise by first day after surgery

How rehabilitation is planned

People with hip fracture commonly have more than one pre-existing medical or psychological problem. Each person therefore faces a very individual set of challenges. There can be no 'one size fits all' plan for the physiotherapy that patients should be offered.

Instead, physiotherapists need to understand the patient's previous medical history and how they were getting around at home before their hip fracture. Only by understanding these factors will they be able to agree a rehabilitation plan and SMART goals.

What is rehabilitation planning?

The CSP states that the main aim of rehabilitation is to return people to their pre-fracture status and reduce their risk of serious injury from further falls. In planning rehabilitation, there needs to be a good understanding of the individual's pre-fracture status, as this will inform the long-term aims of rehabilitation. The rehabilitation plan is formulated in partnership with the patient/carer, includes short- and long-term goals (with timescales) and identifies those who will deliver the plan. The plan should be evaluated regularly to remain effective and relevant to the patient's changing circumstances and health status. It can also be used as a basis for handover of care to the next steps and community services.

We asked physiotherapists about this, and they reported that rehabilitation goals had been agreed for six out of seven patients. This approach varied considerably between hospitals – performed for nearly all patients in 41 hospitals, but not at all in seven hospitals.

Hip Sprint's facilities audit asked hospitals whether they were 'able to continue physiotherapist-led rehabilitation for all hip fracture patients every day until they have achieved their rehabilitation goals'.

39% of sites were able to deliverer this rehabilitation 7 days a week, one third (32%) of sites could do this Monday to Friday, but 28% reported that they were unable to offer this.

What do physiotherapy sessions consist of?

Everyone is different. Some people will be determined to get in and out of bed and walk well enough to get home quickly, but others may be profoundly frightened by their fall and have completely lost their self-confidence. Some find that long-standing problems with their mobility are worsened by the fracture, and others will have had previous problems with gait (walking), balance and falls.

The physiotherapy that each person needs will therefore vary, but Hip Sprint asked physiotherapists working in the acute wards 'What rehabilitation was provided each day of the first week postoperatively?', so that they could record the focus of therapy sessions over the first week. The complex nature of therapy sessions is demonstrated by Figure 2.

Physiotherapy sessions are complex, and therapists recorded working on a number of rehabilitation themes, including strength and balance to help avoid future falls and injuries to help regain confidence after this hip fracture.

The greatest emphasis was placed on work to improve patients' ability to walk and 'transfer' between bed and chair – the key factors determining how soon they might be able to return home. Mobility and transfers were the dominant issues in the first days, but became less so later in the week.

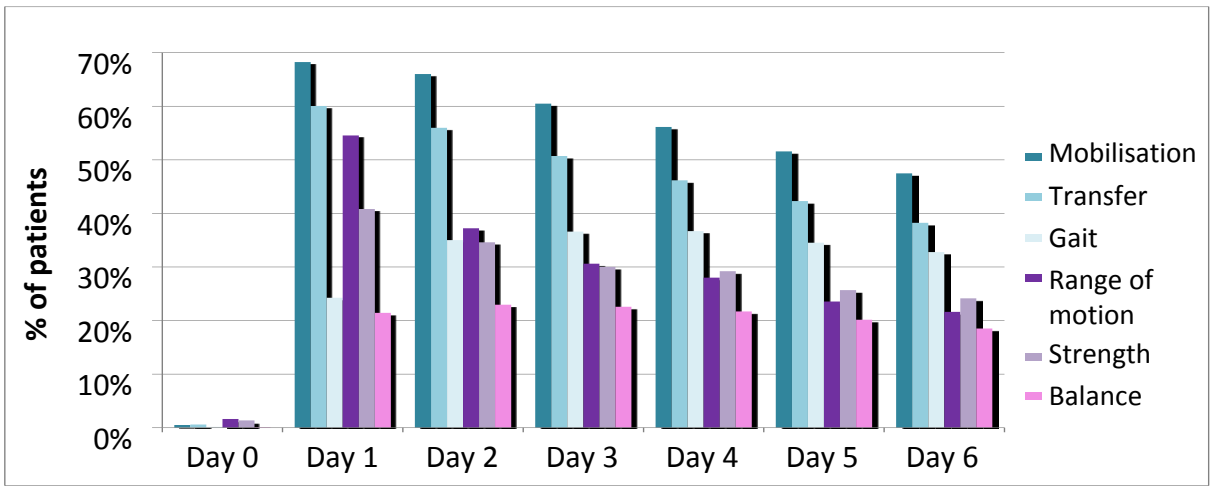

Figure 2 Components of therapy offered over the first week after surgery

How much therapy do patients receive?

Patients' pre-fracture status has a huge influence on plans for their rehabilitation. Fitter people may rapidly get back onto their feet, while others may need a number of members of staff and a hoist or other equipment before they can get out of bed, and a few will have been completely immobile pre-fracture and will have little need for physiotherapy.

As a result, average figures are not necessarily a useful guide to how much therapy would be appropriate. However, we examined this question in detail, as it could help to guide different hospitals as to how much staff time they need to provide.

To capture patients' experience of therapy, physiotherapists were asked 'For how long was the patient mobilising or receiving physiotherapy?' for each day in the first week after surgery.

Few patients received therapy on the day of surgery, but the average time on the day following surgery averaged just under half an hour (27 minutes), and gradually reduced over the rest of the week (Figure 3).

On average, each patient received 2 hours of physiotherapy (118 minutes) in the first week after their operation. People received nearly half an hour (27 minutes) on the day after surgery, but this slowly reduced to 14 minutes by the end of the week.

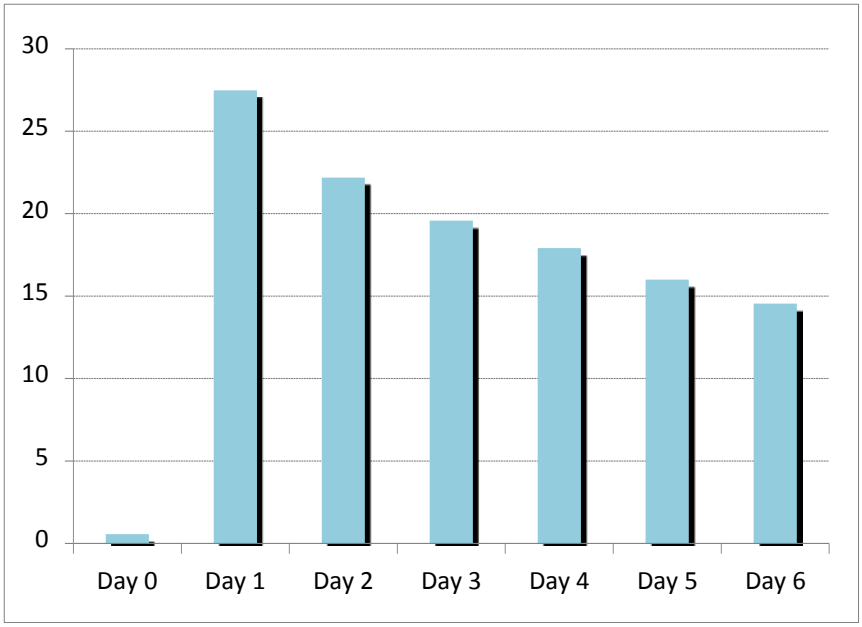

Figure 3 Total time receiving physiotherapy each day (minutes) in the first week after surgery

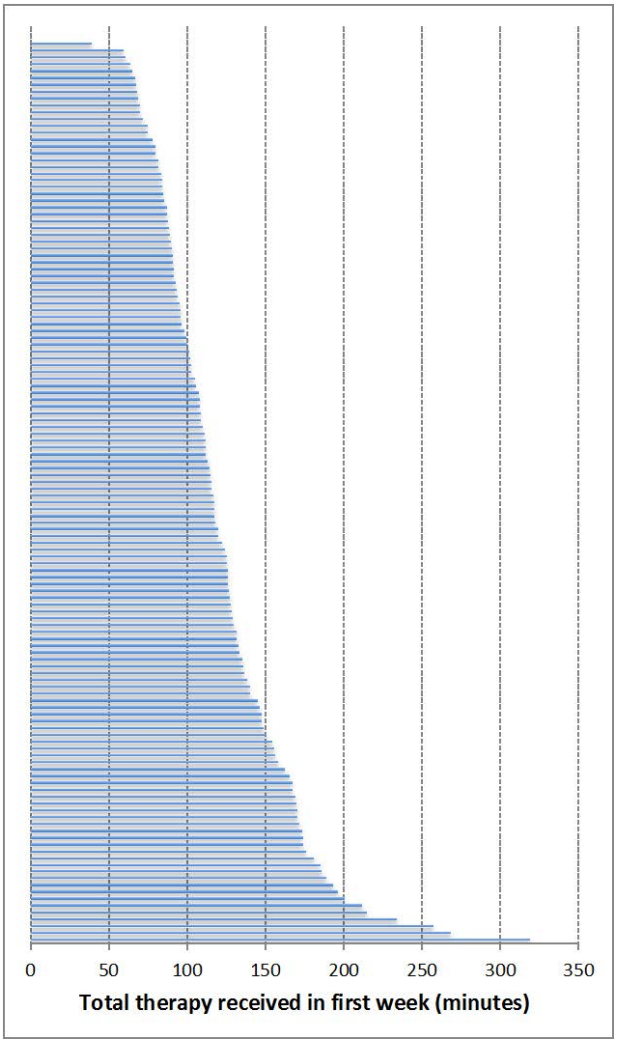

Figure 4 Variation in the average therapy received in the first week after surgery in different hospitals

Who provides rehabilitation?

The staff involved in providing therapy varied considerably. Sessions were usually led by physiotherapists or physiotherapy assistants, but some units described innovative approaches with occupational therapists bringing their additional understanding of patients' lives into combined therapy sessions that addressed aspects beyond mobility. The total number of staff involved in each therapy session varied for different patients.

On average, in the first week of a patient's therapy they required over 3.5 hours of staff time – about 2 hours of this being physiotherapist time, with the remainder provided by physiotherapy assistants or other ward staff (figure 5).

The amount of time staff spent in providing therapy varied hugely across the country, from less than 1 hour in some units, up to several hours of staff time in others. Local results can be found on our interactive maps at **www.fffap.org.uk/phfsa**.

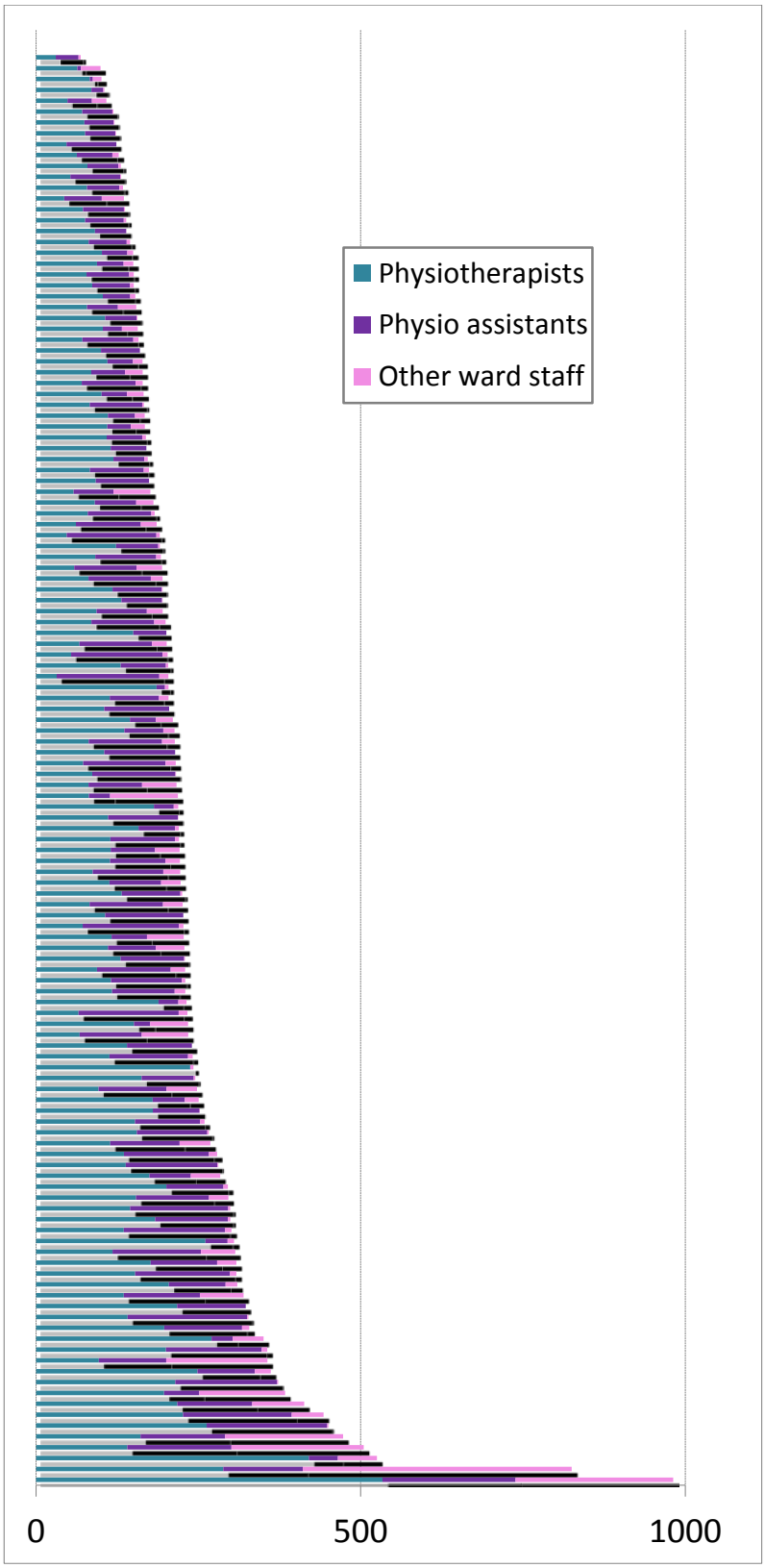

Figure 5 Contributions to therapy in the first week after surgery (therapist time in minutes)

Provision of daily rehabilitation

NICE recommends that patients should receive daily rehabilitation after surgery for hip fracture, but in practice this is not always achieved.

> **National Institute for Health and Care Excellence CG124 (2011)**
>
> Offer patients a physiotherapy assessment and, unless medically or surgically contraindicated, mobilisation on the day after surgery.

For each day, physiotherapists were asked 'If a patient was not successfully mobilised, why not?'. The reasons recorded were fairly consistent throughout the week, with the exception of the first day after surgery. Day 1 mobilisation was more affected by patient factors that make therapy inappropriate, but was clearly prioritised at weekends and much less likely to be affected by weekend staffing than other days.

The importance of helping people to get up on the day after surgery was clearly recognised and staff availability was a limitation for only 1.0% of people on the day after surgery.

However, this prioritisation of day 1 mobilisation meant that staffing became several times more important as a constraint on subsequent days. 42.7% of people missed a day's therapy in the first week for reasons that were at least in part related to staffing.

One in a hundred people (1.1%) missed a day of therapy because appropriate equipment was not available, and one in eight (12.1%) missed a day for reasons that were not recorded.

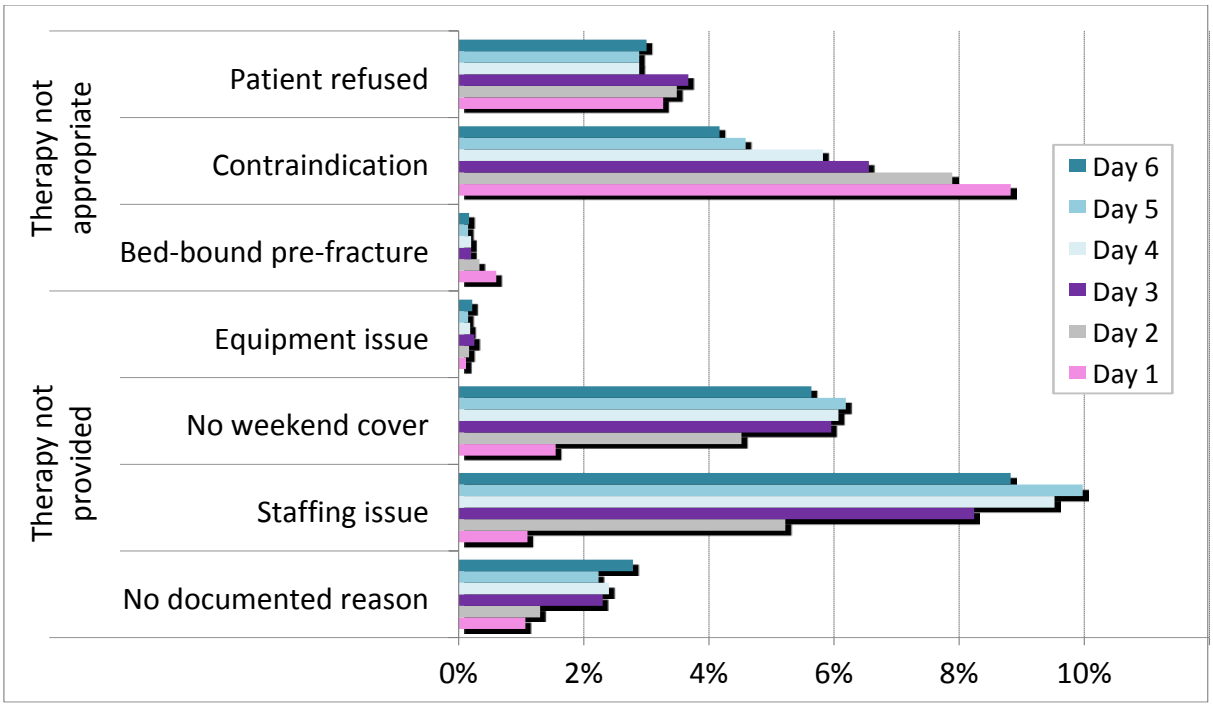

Figure 6 Constraints on provision of physiotherapy

Weekend rehabilitation

Previous work has shown that people who suffer a hip fracture on a Friday and Saturday are less likely to receive surgery by the following day, but it is reassuring that this does not mean that they are any less likely to recover from the injury.

Participating therapists were encouraged to identify when staffing constraints prevented them from delivering all the therapy that a patient might need, or that NICE recommends. Physiotherapists rarely recorded therapist staffing or equipment availability as the reason why someone did not get up by the day after surgery.

However, Hip Sprint found that patients were significantly less likely to be mobilised from bed on the day after surgery at the weekend – only 63% of patients successfully got out of bed at the weekend, compared with 75% on weekdays.

In part, this seems to reflect poorer therapist staffing provision at weekends. Therapy sessions on Saturday and Sunday only lasted for 79% as long (and involved only 75% of the staff time) as those provided to postoperative patients during the working week.

Physiotherapy assistants were less likely to be involved in this weekend work – 29.6% of units employ only physiotherapists or supervised trainees at weekends, compared with 10.8% of units that were staffed like this on weekdays.

These Hip Sprint findings should encourage physiotherapists to recognise their obligation to raise concerns if staffing pressures mean that they are unable to meet NICE guidance.

Therapy on the first day after operation	Weekday	Weekend	Ratio weekend/weekday
Successfully mobilised from bed (%)	75%	63%	84%
Length of physiotherapy time (minutes)	30	24	80%
Total therapist staff time (minutes)	62	46	74%

Table 2 Investment in physiotherapy and mobilisation at weekends (compared with weekdays)

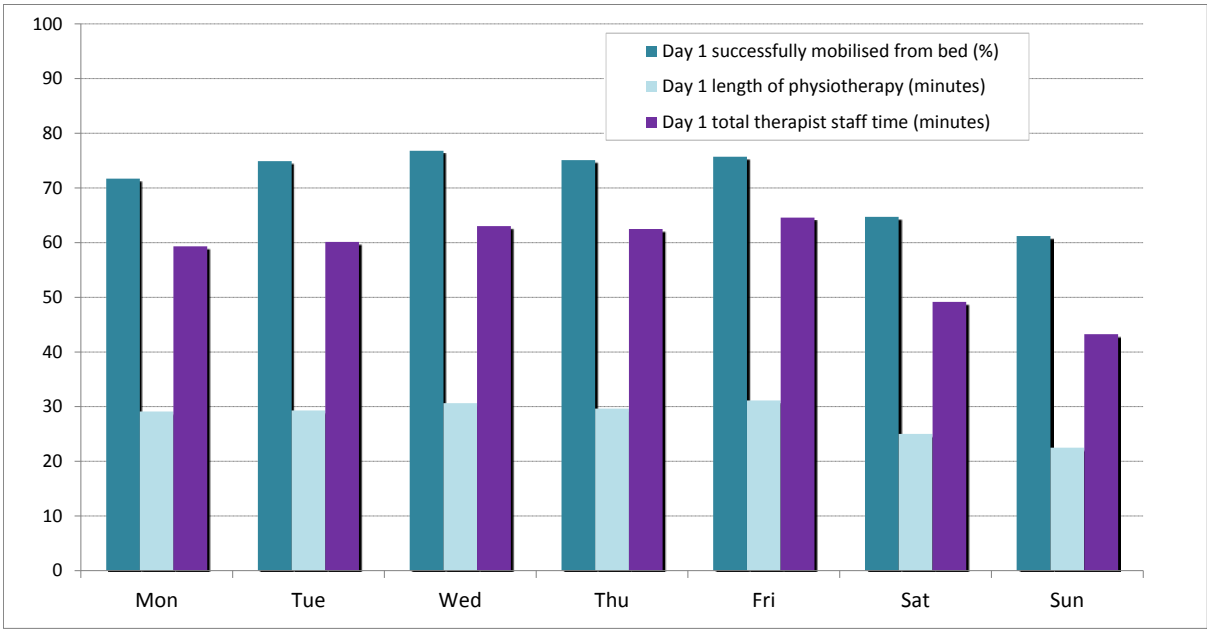

Figure 7 Variation in time invested in day 1 therapy and successful mobilisation across the week

Monitoring the outcome of acute care

Patients and their loved ones consider their quality of life and personal experience of care as being important to complement commonly used outcome measures such as mortality.

Functional outcome measures seek to assess physical function following hip fracture rehabilitation, whereas quality of life measures attempt to assess the general (mental, physical, social, employment, family) impact of the fracture and subsequent rehabilitation.

Hip Sprint's facilities audit asked acute units to report which functional outcome measures they routinely used. The Timed Up and Go test was used in 8% of units, the Barthel Index and New Mobility Score were each used by 5%, the Functional Independence Measure was used by one unit, and 25% of units used another measure. Physiotherapists in 30% of units reported that they had no means of monitoring functional outcome, while those in another 25% of units reported use of the NHFD measure of indoor/outdoor walking status.

We also asked 'What quality of life outcome measures do you routinely use?', in response to which we found that only 6% of people had their quality of life measured in the acute setting. In most instances, this would occur towards the end of the rehabilitation pathway.

2 The next step

How do acute wards link to the next step in the rehabilitation pathway?

On average, people stayed in the first ward for 2 weeks (15 days). This figure includes many who stayed for several weeks as a result of medical and surgical problems. Over half of people were discharged home or moved to another ward or hospital within 2 weeks.

Many hospitals are organised so that surgical care happens in an 'acute' ward, from which patients may move on to another ward in the same hospital for rehabilitation.

This may mean that patients are able to move closer to their home, or happen because the next ward is configured around a specialist MDT of nurses, therapists and doctors who focus on rehabilitation.

In some areas the pathway of care are relatively simple, reflecting a compact geographical area or innovative service design. An example of this is seen in Homerton University Hospital NHS Foundation Trust (Figure 8a).

Figure 8a Mapping an early supported discharge programme through Homerton University Hospital NHS Foundation Trust

In other areas, a central acute unit may work with a whole series of community hospitals and services that provide the next step in the rehabilitation pathway and/or rehabilitation in the patient's home.

An example of this is provided by Chesterfield NHS Foundation Trust (Figure 8b).

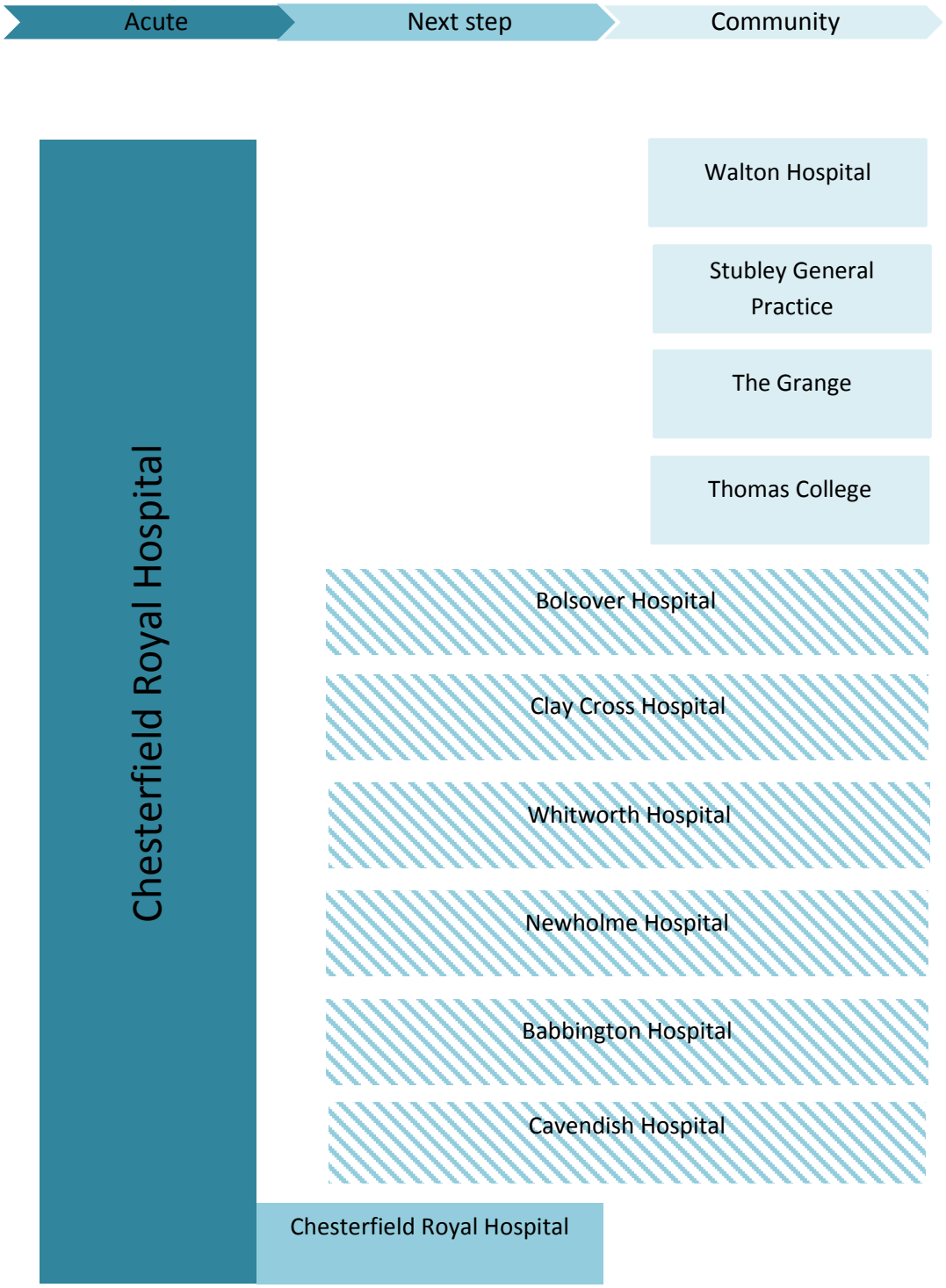

Figure 8b Mapping patient flows through Chesterfield NHS Foundation Trust

Processes for handover between therapists

Handover between different teams poses the greatest challenge to the continuity of care for this frail and complex group of patients.

People presenting with a hip fracture and other conditions are often expected to navigate complex clinical pathways involving a number of wards and healthcare providers. Local clinical teams will often be the only people in a position to appreciate the risks associated with a patient's move between wards, hospitals or services.

Moves should be avoided if possible, but if they are necessary then clinical teams have an obligation to anticipate their impact on the individual and to develop effective mechanisms for handover of information – between physiotherapists in different teams, and by providing structured information to other staff, to patients, their families and their carers.

Hip Sprint identified a variation in clinical handover. All three areas audited – acute, next step and home – reported that approximately one-third of patients were handed over via email, approximately one-tenth via fax and approximately one-tenth were written in MDT meeting notes. Two-fifths of patient handovers were completed by other forms of written documentation and 5% of patients were handed over by phone; however, this was only by acute sites.

Community physiotherapists reported that nine out of ten patients were handed over to them from the upstream services. However, conversely this means that one in ten patients were not handed over at all. This could be attributed to no clinical handover occurring, or the handover may not have been directly to the patient therapist.

Rehabilitation planning

When we asked physiotherapists about this, they reported that rehabilitation goals had been agreed for six out of seven patients (as they had in the acute wards), but again this approach varied considerably between hospitals. Ranging from routine for everyone in most wards, to not performed at all in five hospitals.

How much therapy do patients receive?

Different hospitals have developed very different types of wards, often for historical reasons or as a result of the enthusiasm of individual clinical teams.

The intensity of physiotherapy in each ward can be judged from the amount of physiotherapist time invested in each patient's care. Total staff time depends on whether people need more than one therapist or other member of staff to work with them.

On average, during the first week after transfer, patients received over an hour and a half of trained physiotherapist time per day, an hour of physiotherapy assistant time and three quarters of an hour of time from other staff, including occupational therapists.

This is similar to the staff time involved in providing therapy in the acute ward (Table 3, Figure 9), but at that time patients may have needed more pairs of hands to help them, and may have been less able to cope with prolonged therapy.

As a result, patients in the next step ward might expect to spend nearly 20 minutes more in physiotherapy each day than they received in the acute ward in the week after surgery (Figure 10).

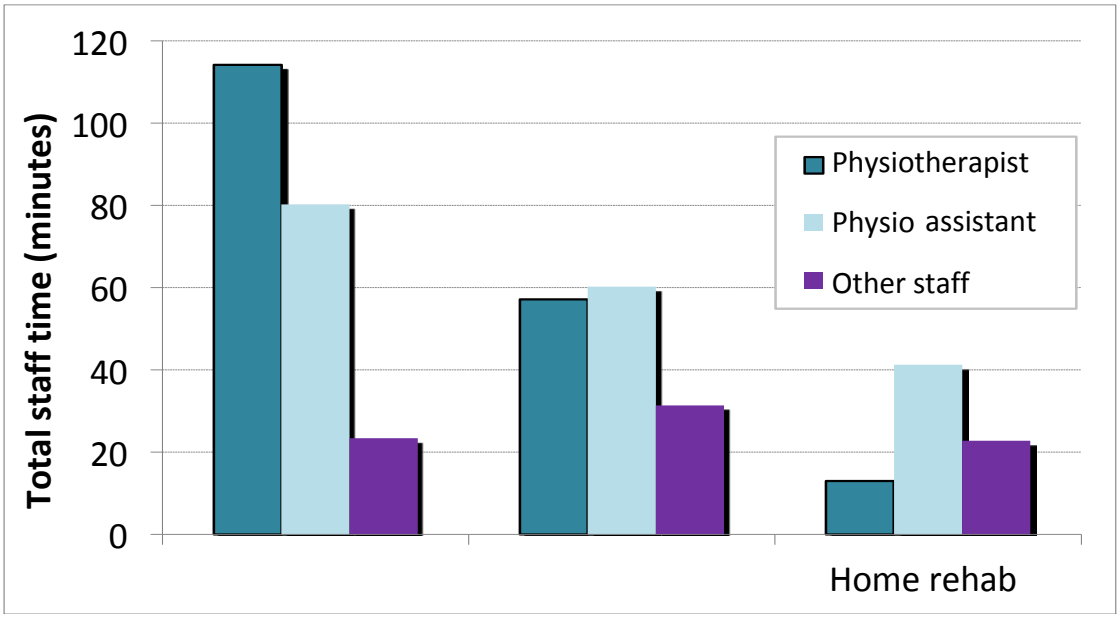

Figure 9 Total staff time invested in therapy in first week for each setting

	Acute ward			Next step			Home rehabilitation		
Day	Physio	Assistant	Other	Physio	Assistant	Other	Physio	Assistant	Other
0	0.5	0.2	0.1	11.9	5.1	5.3	25.6	16.4	5.0
1	30.7	18.6	4.6	22.5	11.0	8.5	5.5	4.9	3.2
2	23.0	15.2	4.1	15.2	8.2	6.8	3.2	4.3	2.8
3	18.9	13.5	3.8	14.6	8.2	7.7	2.4	3.7	2.9
4	16.2	12.2	3.6	12.4	8.2	7.1	2.1	3.7	2.3
5	13.7	10.7	3.2	12.5	8.9	6.2	2.3	3.9	2.4
6	11.1	9.8	3.2	12.9	10.6	7.9	3.0	4.4	2.9
Total	**114.1**	**80.2**	**22.6**	**101.9**	**60.2**	**49.4**	**44.1**	**41.3**	**21.3**
	217.0			**211.6**			**106.7**		

Table 3 Staff time invested in the first week of therapy for each setting (minutes)

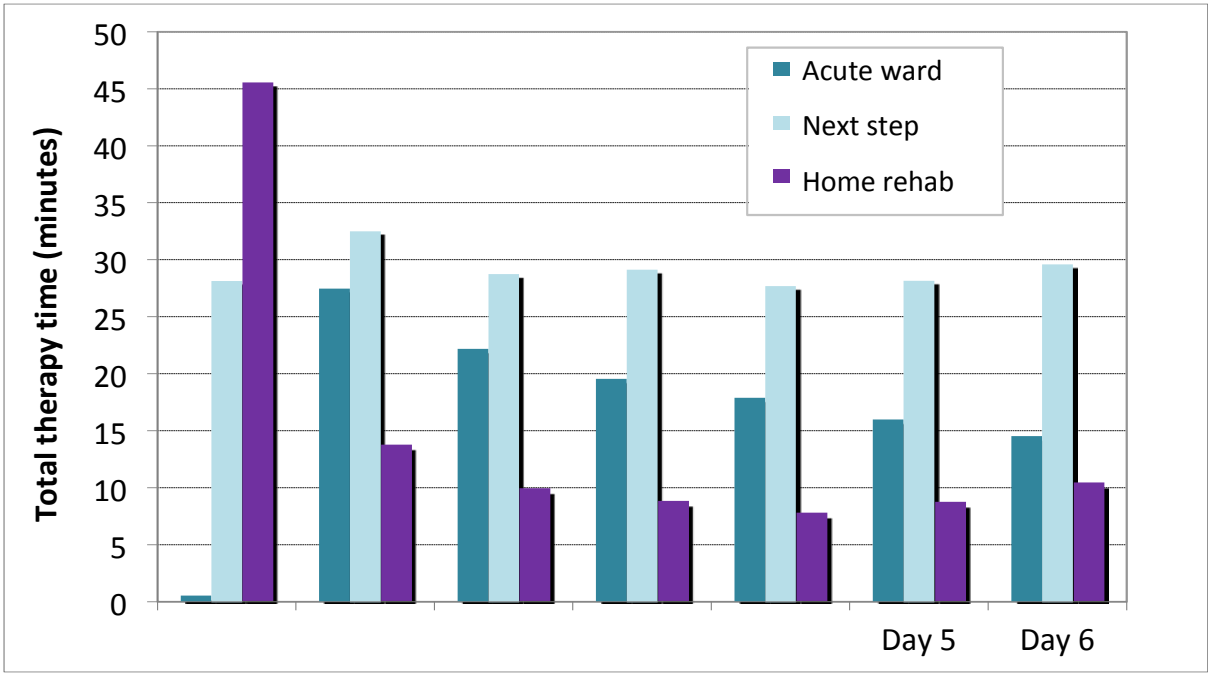

Figure 10 Total time receiving therapy in first week for each setting (minutes)

3 Home rehabilitation

How soon does rehabilitation at home start?

Different areas have developed different services, most of which aim to work with patients soon after their discharge home. In some cases, this is on the following day or within the same week, but on average we found that patients had to wait slightly more than 2 weeks (15.2 days) between discharge home and the start of physiotherapy.

Figures for some units were too small to provide reliable average figures, but five units that reported on more than ten cases described average delays of 1 month between people going home and rehabilitation starting (Figure 11).

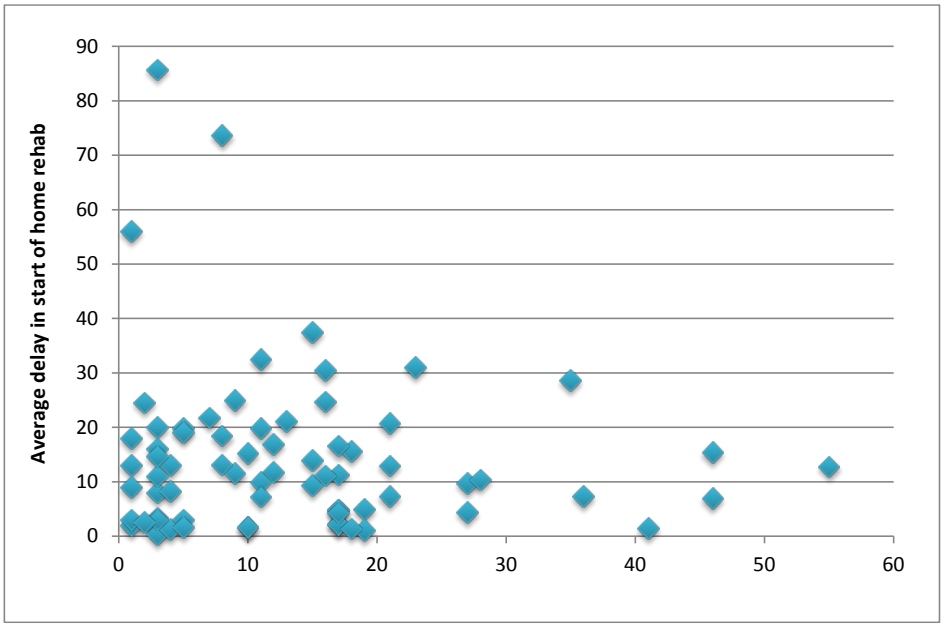

Figure 11 Time patients waited for start of home rehabilitation (days)

One in five services (20.5%) successfully maintained the continuity of their patients' rehabilitation, providing what Hip Sprint viewed as an acceptable interval of no more than 1 week between a patient's discharge and the start of physiotherapy in their own home (Figure 12).

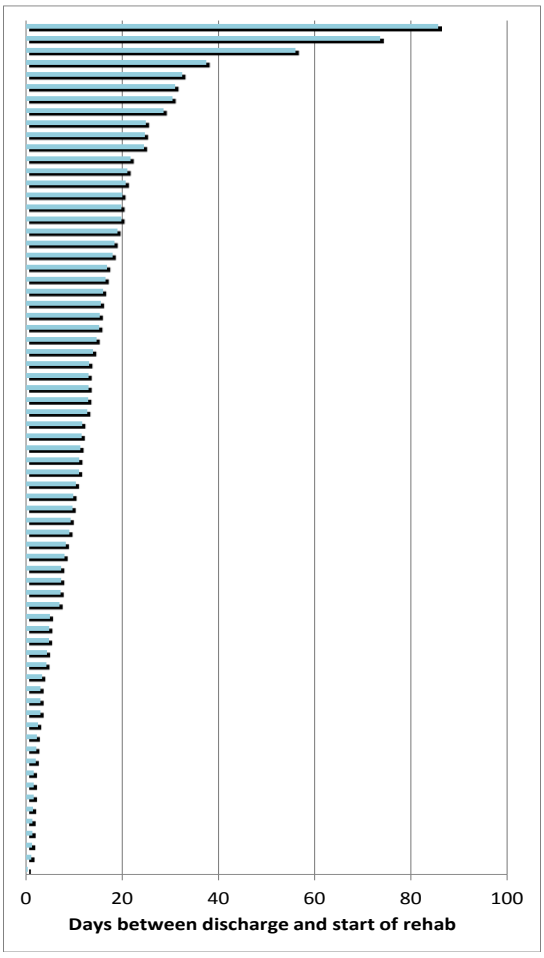

Figure 12 Average number of days between discharge and start of home rehabilitation in different community services

How much therapy do patients receive?

The type of staff involved varied between different patients and different services, but trained physiotherapists provided a smaller proportion of community therapy than was reported in hospital. In the first week after discharge, an average of nearly 2 hours of staff time was invested in therapy – around half the time that was being provided while they were inpatients.

Physiotherapist and physio assistant time each accounted for nearly three-quarters of an hour of this total, with just over 20 minutes provided by occupational therapists, nurses and other staff.

Different services varied in how often people were seen during the first week at home. Most people received therapy on more than one day (mean: 2.2 days/week), but Hip Sprint identified 12 community rehabilitation services that reported providing therapy on an average of over 4 days of the first week of their involvement with patients (Figure 13).

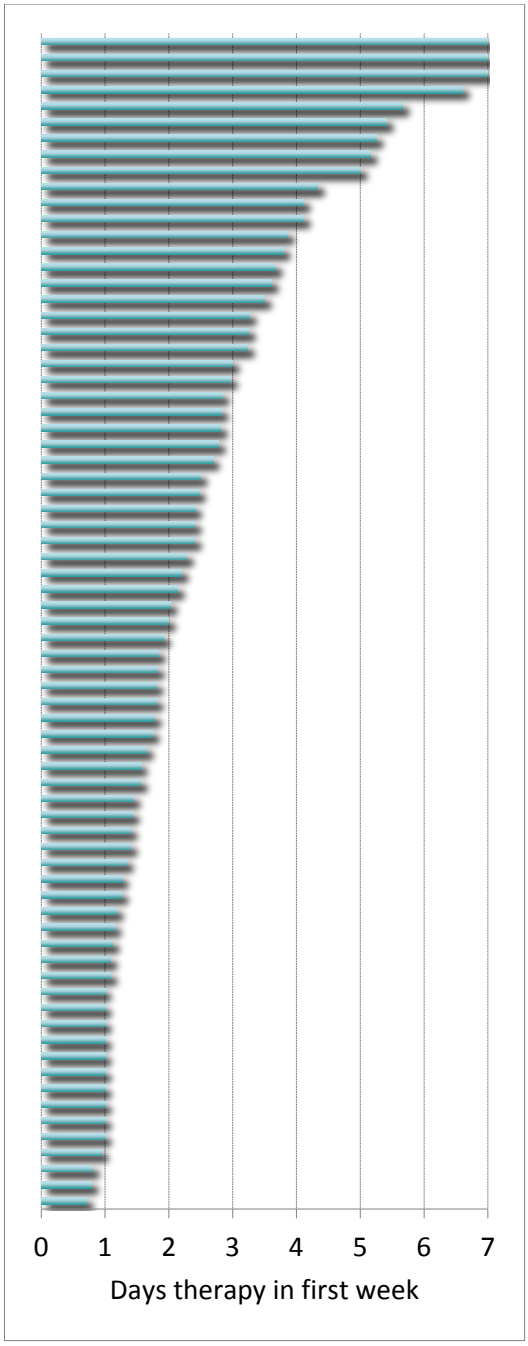

Figure 13 Frequency of home therapy in the week after community rehabilitation starts for different community services

Do patients receive therapy if they return to live in a care home?

One-quarter of people who present with a hip fracture were previously living in a residential or nursing care home. Such people may be mentally and physically frail, and their time in hospital often proves challenging. A return to the more familiar setting of their care home may be appropriate, but this should not automatically mean that they stop receiving physiotherapy and rehabilitation.

National Institute for Health and Care Excellence CG124 (2011)

Patients admitted from care or nursing homes should not be excluded from a rehabilitation programme in the community or hospital or as part of an early supported discharge programme.

Hip Sprint found that 11.8% of services accepted that they were unable to comply with the NICE recommendation that people should not be excluded from community rehabilitation if they are discharged back to their original care home after hip fracture.

Where sufficient NHFD and Hip Sprint data are available for individuals, it would be useful for Hip Sprint follow-up work to consider the extent to which the majority of units (88.2%) are actually delivering rehabilitation to this specific group of frailest patients.

4 Outcome

The outcome of hip fracture is complex and multifaceted. Comparisons of different services are frequently dominated by casemix-adjusted mortality, but patients often place greater emphasis on restoration of mobility and independence, and most value a return to living in their own home above other objectives.

Hip Sprint's approach reflected this – we set out to examine whether the quality and intensity of physiotherapy might affect hospitals' success in delivering this outcome.

How likely are patients to return home?

The majority of people will be able to return to their previous residence. Most would prefer that this happens directly from the first ward to which they were admitted.

On average, we found almost half (48.6%) of people who were admitted from their own home or sheltered housing were able to return there directly from the acute ward – but this figure varied enormously between hospitals, from nearly none in some hospitals to nearly everyone in others (Figure 14).

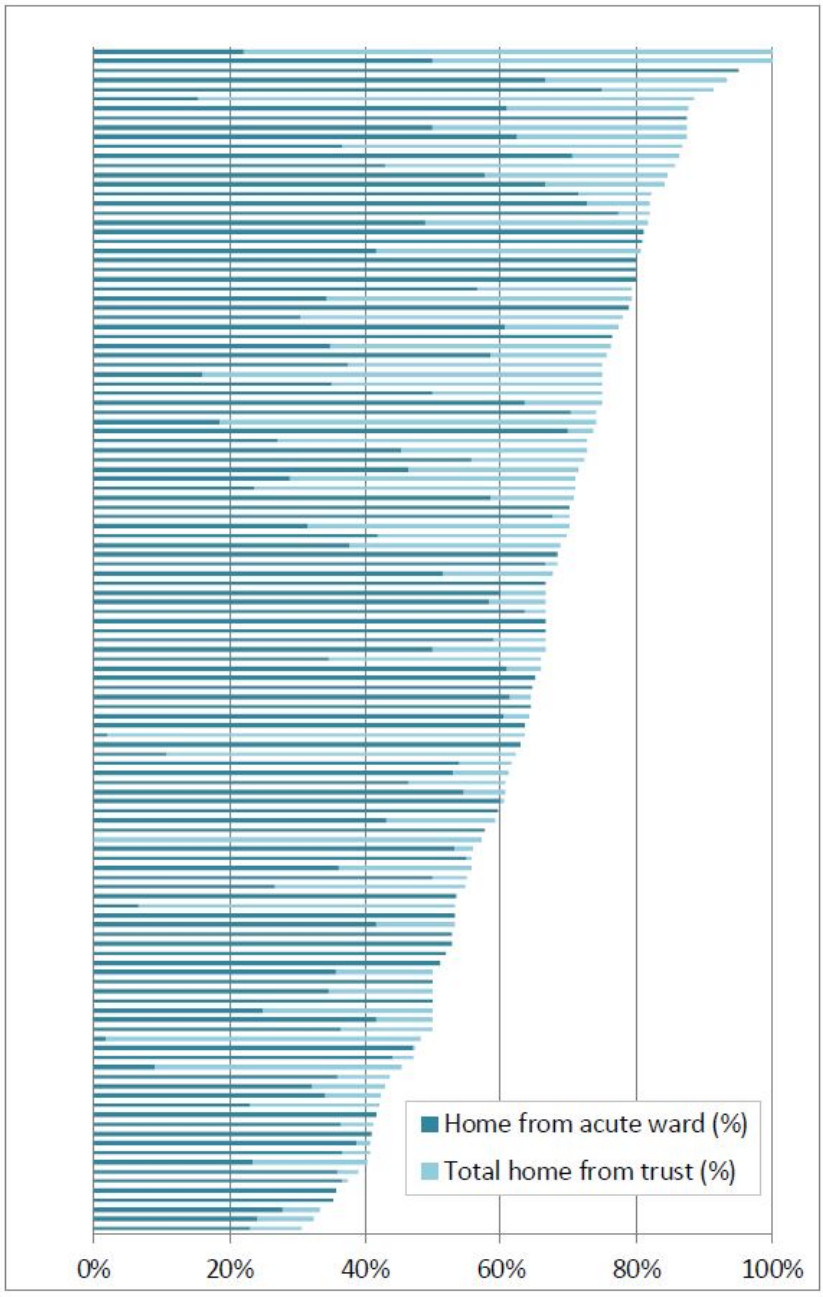

Figure 14 Comparison of rates of return home reported by individual acute hospitals

The more therapist time that was able to be invested during the first week, the more likely it was that people would return to their own home. The same effects were seen when the intensity of physiotherapy is considered from the patient's perspective.

On average, patients received 2 hours of therapy in the first week after surgery (an average of 20 minutes a day from postoperative day 1 to day 6).

Acute wards that were able to provide more intensive physiotherapy were more likely to succeed in getting patients up on the day after surgery, less likely to need to transfer them to another ward for rehabilitation, and more likely to return patients straight home (Table 4).

This effect is complex, as the intensity of therapy received is not just a matter of the quality and intensity of physiotherapy. Hospitals that provide high-quality perioperative surgical, anaesthetic and medical care will minimise the number of patients who are too unwell to receive therapy.

If the figures achieved in acute wards providing more than 20 minutes of therapy a day were replicated across the whole country, then over 1,000 more people might be able to return directly home each year. On the other hand, the acute wards that provided less intensive initial therapy also transferred more patients to rehabilitation and so achieved overall rates of return home that were as good as those with more intensive early therapy.

Therapy received – day 1 to day 6 of postoperative week			
	Less than 20 mins	**More than 20 mins**	**All units**
Number of units	68	57	125
Number of patients	3,435	2,514	5,949
	Investment in daily physiotherapy		
Mean number of staff per therapy session	1.8	1.9	1.9
Mean staff time (minutes/day)	28.6	48.2	36.9
Mean therapy received (minutes/day)	15.6	25.3	19.5
	Rehabilitation pathway		
Mobilised on postoperative day 1	67.8%	69.1%	68.4%
Transfer to another ward for rehabilitation	31.4%	28.2%	30.0%
	Patients returned to their own home		
Directly home from the acute ward	1,270 (47.3%)	1,009 (50.3%)	2,279 (48.6%)
Returned home from trust overall	1,700 (63.3%)	1,272 (63.5%)	2,965 (63.1%)

Table 4 Proportion of people returning directly to their own home vs intensity of therapy in the week after surgery

Final residence after physiotherapy

It is difficult to be confident where patients end up living after their physiotherapy, because when following people up at 4 months some local teams may have heard back from disproportionate numbers of those who were particularly healthy or of those now living in care homes.

Four-fifths (81%) of people were living at home or in sheltered accommodation before the hip fracture. Follow-up data suggests that this had fallen to two-thirds (65%) after 4 months.

One-fifth (19%) of people were living in care homes before their hip fracture, and by 4 months this had risen to one-quarter; 12% in nursing homes and 13% in residential care.

Recovery of mobility after physiotherapy

Most people will have finished rehabilitation by 4 months after hip fracture.

One in three (37%) people told us that they had been walking freely without aid before the hip fracture, but by 4 months post-fracture, only one in ten (10%) were walking this well.

One in five (19%) of all people said that they now needed one stick or crutch, and one in six (17%) needed two sticks or crutches or a walking frame to go outdoors.

Before hip fracture, only one-quarter (25%) of people said that they never went outside, but could get around indoors, and this figure had risen to one-third (35%) at 4-month follow-up.

One in ten (9%) people had become completely immobile following their hip fracture.

Appendix A: Case studies

Homerton Hospital (acute)

Josephine experienced delirium while recovering in hospital following a hip fracture. There were periods where she could not recall important events, where she was or her recent surgery.

Prior to her fracture, she lived on her own in a third-floor flat, was independent with her activities of daily living and would frequently go out on the bus to go shopping and meet friends. She had recently been considering moving to a supported living scheme, but had decided that she wanted to stay living in her flat for a while longer.

Taking positive action to address potential risks, the Early Supported Discharge team helped Josephine's to participate in rehabilitation and recovery in the familiar environment of her home.

The team supported her wish to return to her home, acknowledging that the hospital environment was likely to be contributing to her delirium. An occupational therapy (OT) home visit confirmed that it would be safe for Josephine to return home, providing that risks were minimised. These included concerns about her cognition and delirium, her safety awareness, poor nutrition and continence.

Josephine went home with the support of occupational and physiotherapists, a reablement package, district nursing and Age UK's 'Take Home and Settle' service – initially with daily therapist.

After 2 weeks, Josephine's cognition and function had greatly improved. She reported that the 'mist had lifted'. At her 6-week review meeting with social services, she was able to participate in a discussion about her wishes for her ongoing care needs. She reported 'I like being at home with my things around me, but I also want to be somewhere I will get the care I need'.

Bodmin Hospital (community)

Demelza had extensive lower limb pain following a hip fracture and was holding her operated lower limb in very poor posture. She was reluctant to take weight through her leg due to pain and she felt very concerned when she relayed her feelings to the team that 'I was destined for a hoist and that made me feel very low'.

By adopting a personalised and proactive approach to early mobility following hip fracture the team enabled her to achieve her goal of standing to move between bed and chair.

She was transferred early from the acute hospital to a community hospital rehabilitation bed and at that time, a hoist was being used for all her transfers. The community hospital physiotherapist completed an early assessment which included a further X-ray and review of pain relief.

As a result, more appropriate pain relief was prescribed. The physiotherapist was able to review the X-ray virtually with the orthopaedic team and mobilisation was allowed to continue.

Demelza made steady progress with the rehabilitation team. Work focused on improving her strength, balance and confidence. She was able to increase her ability to bear weight in a standing transfer with decreased pain and improved lower limb posture – she had achieved her goals.

Appendix B: Facilities audit results

Acute

1a

Who typically does the initial physiotherapy assessment for hip fracture patients on weekdays:	
Registered physiotherapists OR physiotherapy assistant at other bands (eg techs, assistants)	66% (49)
Registered physiotherapists (including supervised students) all the time	28% (21)
Registered physiotherapists OR physiotherapy assistant at other bands OR other staff (eg nurses, OTs, OT assistants)	5% (4)

1b

Who typically does the initial physiotherapy assessment for hip fracture patients on weekends:	
Registered physiotherapists OR physiotherapy assistant at other bands (eg techs, assistants)	73% (53)
Registered physiotherapists (including supervised students) all the time	21% (15)
Registered physiotherapists OR physiotherapy assistant at other bands OR other staff (eg nurses, OTs, OT assistants)	7% (5)

2a

Who typically provides physiotherapist-led rehabilitation on weekdays in the first week post-op:	
Registered physiotherapists OR physiotherapy assistant at other bands (eg techs, assistants)	11% (8)
Registered physiotherapists (including supervised students) all the time	66% (49)
Registered physiotherapists OR physiotherapy assistant at other bands OR other staff (eg nurses, OTs, OT assistants)	23% (17)

2b

Who typically provides physiotherapist-led rehabilitation at weekends in the first week post-op:	
Registered physiotherapists OR physiotherapy assistant at other bands (eg techs, assistants)	30% (21)
Registered physiotherapists (including supervised students) all the time	41% (29)
Registered physiotherapists OR physiotherapy assistant at other bands OR other staff (eg nurses, OTs, OT assistants)	30% (21)

3a

On which days of the week are physiotherapists available to mobilise patients on the day after their hip fracture surgery:	
Monday to Friday	3% (2)
Monday to Saturday (full day Saturday)	1% (1)
Monday to Sunday (½ day Saturday and ½ day Sunday)	30% (22)

Monday to Sunday (Saturday and Sunday full days)	65% (48)
Monday to Sunday (Saturday full day and Sunday ½ day)	1% (1)

3b

What are your services' normal working hours on week days:	
Monday to Friday (0800–1600/1700)	95% (70)
Monday to Friday (extended hours)	5% (4)

3c

Are you able to continue physiotherapist-led rehabilitation for all hip fracture patients every day until they have achieved their rehabilitation goals:	
Yes – every day	39% (29)
Just Monday to Friday	32% (24)
No	28% (21)

4

What do you feel limits your ability to provide physiotherapist-led rehabilitation:	
Absence (sick/maternity)	7% (5)
Absence (sick/maternity), Hospital capacity (beds)	1% (1)
Absence (sick/maternity), No weekend staff cover	3% (2)
Hospital capacity (beds)	11% (8)
Lack of equipment	1% (1)
Lack of physiotherapy full time equivalent	14% (10)
Lack of physiotherapy full time equivalent, Absence (sick/maternity)	15% (11)
Lack of physiotherapy full time equivalent, Hospital capacity (beds)	15% (11)
Lack of physiotherapy full time equivalent, Lack of equipment	1% (1)
Lack of physiotherapy full time equivalent, No weekend staff cover	18% (13)
No weekend staff cover	4% (3)
No weekend staff cover, Hospital capacity (beds)	1% (1)
No weekend staff cover, Lack of equipment	1% (1)
None	8% (6)

5

Do physiotherapists attend a trauma and orthopaedic clinical governance meeting:	
No – regular meetings take place but physiotherapists do not attend	30% (22)
None occur	7% (5)
Yes – physiotherapists attend a regular monthly/alternate monthly meeting	63% (46)

6a

How many wards in your hospital does your acute service routinely refer patients to for rehabilitation:	Count
0	37
1	12
2	15
3	5
4	1
5	1
10	1
14	1

6b

How many wards/units outside of your hospital does your acute service routinely refer patients to for rehabilitation:	Count
0	6
1	10
2	10
3	11
4	8
5	7
6	5
7	6
8	4
9	1
10	1
11	1
12	2

6c

How many wards/units outside of your hospital does your acute service routinely refer patients to for rehabilitation:	Count
0	23
1	9
2	14
3	5
4	4
5	7
6	1
8	1
9	1
10	4

7

How many community rehabilitation services outside of your hospital does your acute service routinely refer patients to:	Count
0	3
1	8
2	19
3	12
4	5
5	11
6	5
7	2
8	3
9	2
12	1
14	1

8

Do you routinely hand over patient information to the next step or community physiotherapist:	
No	4% (3)
Yes – email	31% (23)

Yes – fax	11% (8)
Yes – telephone	5% (4)
Yes – written in MDT notes	14% (10)
Yes – written other (physiotherapy specific documentation)	35% (26)

9

What functional outcome measures do you routinely use:	
Barthel index	5% (4)
Functional independence measure	1% (1)
Indoor/outdoor walking status	25% (18)
New mobility score	5% (4)
None	30% (22)
Other	25% (18)
TUG	8% (6)

10

What quality of life outcome measures do you routinely use:	
None	95% (69)
Other	6% (4)

11

What physical resources are routinely available to you:	
Exercise prescription tool (eg physio tool computer software) only	1% (1)
Gait and transfer training equipment (eg parallel bars, pulpit frames, stand aids) only	7% (5)
Exercise prescription tools, exercise equipment and gait and transfer equipment	48% (34)
Exercise prescription tool and exercise equipment	3% (2)
Exercise prescription tool and gait and transfer training equipment	28% (20)
Exercise equipment and gait and transfer training equipment	13% (9)

12

Do you have adequate space for post-op physiotherapist-led rehabilitation:	
No	51% (37)
Yes – therapy area elsewhere in the hospital	16% (12)
Yes – we have a therapy area on the ward	16% (12)
Yes – we have enough space within the ward	16% (12)

Next step

1a

Who typically provides physiotherapist-led rehabilitation on weekdays for hip fracture patients:	
Registered physiotherapists (including supervised students) all the time	9% (5)
Registered physiotherapists OR physiotherapists at other bands (eg techs, assistants etc.)	54% (32)
Registered physiotherapists OR physiotherapy assistant at other bands OR other staff (eg nurses, OTs, OT assistants)	37% (22)

1b

Who typically provides physiotherapist-led rehabilitation at weekends for hip fracture patients:	
Registered physiotherapists (including supervised students) all the time	3% (1)
Registered physiotherapists OR physiotherapists at other bands (eg techs, assistants etc.)	18% (7)
Registered physiotherapists OR physiotherapy assistant at other bands OR other staff (eg nurses, OTs, OT assistants)	79% (30)

2

What are your services' normal working hours on weekdays:	
Monday to Friday (0800–1600/1700)	93% (56)
Monday to Friday (extended hours)	7% (4)

3

Are you able to continue physiotherapist-led rehabilitation for all hip fracture patients every day until they have achieved their rehabilitation goals:	
Just Monday to Friday	71% (42)
No	14% (8)
Yes – every day	15% (9)

4

What do you feel limits your ability to provide physiotherapist-led rehabilitation (select top two):	
Absence (sick/maternity)	7% (4)
Absence (sick/maternity), No weekend staff cover	15% (9)
Lack of equipment	2% (1)
Lack of physiotherapy full time equivalent	8% (5)
Lack of physiotherapy full time equivalent, Absence (sick/maternity)	5% (3)

Lack of physiotherapy full time equivalent, Hospital capacity (beds)	3% (2)
Lack of physiotherapy full time equivalent, Lack of equipment	5% (3)
Lack of physiotherapy full time equivalent, No weekend staff cover	25% (15)
No weekend staff cover	20% (12)
No weekend staff cover, Hospital capacity (beds)	7% (4)
No weekend staff cover, Lack of equipment	2% (1)
None	2% (1)

5

Do physiotherapists attend a trauma and orthopaedic clinical governance meeting:	
No – regular meetings take place but physiotherapists do not attend	17% (10)
None occur	76% (45)
Yes – physiotherapists attend a regular monthly/alternate monthly meeting	7% (4)

6

How many wards/units outside of your hospital does your acute service routinely refer patients to for step-down care:	
0	21
1	5
2	5
3	9
4	5
5	4
6	1
7	1
11	1

7

How many community rehabilitation services outside of your hospital does your acute service routinely refer patients to:	
0	4
1	8

2	17
3	6
4	4
5	5
6	5
7	5
9	1

8

Do you routinely hand over patient information to the community physiotherapists:	
Yes – email	33% (19)
Yes – fax	12% (7)
Yes – written	42% (24)
Yes – written in MDT notes	12% (7)

9

What functional outcome measures do you routinely use:	
Barthel index	4% (2)
Functional independence measure	4% (2)
Indoor/outdoor walking status	26% (15)
None	12% (7)
Other	40% (23)
TUG	14% (8)

10

What quality of life outcome measures do you routinely use:	
EQ – 5D	2% (1)
None	74% (42)
Other	25% (14)

11

What physical resources are routinely available to you:	
Exercise equipment and gait and transfer training equipment	9% (5)

Exercise prescription tool (eg physio tool computer software) only	5% (3)
Exercise prescription tool and exercise equipment	4% (2)
Exercise prescription tool and gait and transfer training equipment	7% (4)
Exercise prescription tools, exercise equipment and gait and transfer equipment	68% (39)
Gait and transfer training equipment (eg parallel bars, pulpit frames, stand aids) only	7% (4)

12

Do you have adequate space for post-op physiotherapy-led rehabilitation:	
Yes – we have a therapy area on the ward	11% (6)
Yes – we have enough space within the ward	60% (34)
No	30% (17)

Home

1a

Who typically provides physiotherapist-led rehabilitation on weekdays for hip fracture patients:	
Registered physiotherapists OR physiotherapy assistant at other bands (eg techs, assistants)	69% (35)
Registered physiotherapists (including supervised students) all the time	8% (4)
Registered physiotherapists OR physiotherapy assistant at other bands OR other staff (eg nurses, OTs, OT assistants)	24% (12)

1b

Who typically provides physiotherapist-led rehabilitation at weekends for hip fracture patients:	
Registered physiotherapists OR physiotherapy assistant at other bands (eg techs, assistants)	41% (12)
Registered physiotherapists (including supervised students) all the time	7% (2)
Registered physiotherapists OR physiotherapy assistant at other bands OR other staff (eg nurses, OTs, OT assistants)	52% (15)

2a

On which days of the week could your service provide physiotherapist-led rehabilitation to hip fracture patients:	
Monday to Friday	58% (29)
Monday to Saturday (full day Saturday)	2% (1)
Monday to Sunday (Saturday and Sunday full days)	40% (20)

2b

What are your physiotherapists' normal working hours on weekdays:	
Monday to Friday (0800–1600/1700)	58% (29)
Monday to Friday (extended hours)	2% (1)

3

On average how long (days) after returning home would a hip fracture patient wait to start physiotherapy in your service:	
Up to 1 week	26
1–2 weeks	10
2–3 weeks	2
4+ weeks	9

4

When do you cease providing physiotherapy rehabilitation to patients after hip fracture surgery:	
Following completion of fixed number of sessions/after a fixed period of time	12% (6)
Patient fit for discharge	86% (42)
Service provision (eg influx of new patients)	2% (1)

5

What do you feel limits your ability to provide physiotherapist-led rehabilitation (select top two):	
Absence (sick/maternity)	5% (3)
Absence (sick/maternity), Lack of equipment	2% (1)
Lack of equipment	2% (1)
Lack of physiotherapy full time equivalent	22% (11)
Lack of physiotherapy full time equivalent, Absence (sick/maternity)	24% (12)
Lack of physiotherapy full time equivalent, Lack of equipment	2% (1)
Lack of physiotherapy full time equivalent, No weekend staff cover	20% (10)
No weekend staff cover	8% (4)
None	16% (8)

6

What physical resources are routinely available to you:	
Exercise prescription tool (eg physio tool computer software) only	5% (3)
Gait and transfer training equipment (eg parallel bars, pulpit frames, stand aids) only	2% (1)
Exercise prescription tools, exercise equipment and gait and transfer equipment	2% (1)
Exercise prescription tool and exercise equipment	20% (10)
Exercise prescription tool and gait and transfer training equipment	24% (12)
Exercise equipment and gait and transfer training equipment	2% (1)

7

How do you typically receive a handover of hip fracture patients:	
Email	32% (16)
Fax	12% (6)

No handover	10% (5)
Written – other (eg physiotherapy specific paperwork)	38% (19)
Written in MDT records	8% (4)

8

Do physiotherapists in your trust provide physiotherapist-led rehabilitation to patients who return to long-term care following their acute hospital stay after hip fracture:	
No	12% (6)
Yes	88% (45)

9

How do you typically receive a handover of hip fracture patients:	
Other	32% (16)
Unknown	12% (6)
As part of a block contract for community rehabilitation	10% (5)
Ring-fenced for hip fracture patients as part of an early support discharge programme	38% (19)

*Please note that individual site data can be found on Crown Informatics webpage: **www.fffap.org.uk/phfsa**

Recovering after a hip fracture:
helping people understand physiotherapy in the NHS

Physiotherapy Hip Fracture Sprint Audit (PHFSA)

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