EDITORIALS

Orthogeriatric medicine and fracture liaison going from strength to strength

The management of patients sustaining a low trauma fracture has changed remarkably over recent years with the acute care of older trauma patients improved by pre-operative assessment, safe anaesthesia and timely surgical intervention. This has been complemented by the British Orthopaedic Association (BOA) Standards for Trauma care for hip fracture (BOAST 1) which synthesise the relevant guidance from the National Institute for Health and Care Excellence (NICE) and the BOA/BGS ‘Blue Book’ on hip fracture management [1, 2]. Since September 2007, the National Hip Fracture Database (NHFD) has been collecting data, with the first annual report (for 2007–8) published in 2009 on core standards of acute and rehabilitative care. In 2010, the best practice tariff (BPT) was introduced to provide extra funding to meet some of these quality standards for the care of hip fracture patients. The national audit of individual patients’ care has reportedly improved standards, with evidence of better clinical outcomes. Even within 4 years (2007–11), as the number of participating hospitals increased from 11 to 175, the rate of early surgery increased from 54.5 to 71.3% and 30-day mortality fell from 10.9 to 8.5% [3]. Whether these changes in practice and outcome were a result of better definition of optimal care by the ‘Blue Book’, the impact of the NHFD audit, the introduction of BPT or (more likely) all three cannot be discerned from the available data.

BOAST 1 and the ‘Blue Book’ highlight a number of factors defining exemplary care and the common sense of prompt admission to an orthopaedic bed, rapid MDT assessment and minimal delay to surgery are standards worth monitoring to reflect improved care likely to result in better outcomes. It is less straightforward to evaluate the accuracy and quality of surgery using simple audit tools, although NICE have cited data from the most recent NHFD report [4], to highlight poor compliance with its recommendations on the indications for total hip replacement in hip fracture [5]. The benefits of prompt mobilisation, MDT rehabilitation and early supported discharge should have contributed to the modest shortening of the average length of stay (LOS) by 0.5 days between 2013 and 2014 [4]. More worrying, perhaps, is the continued variation between hospitals and particularly between nations, as the mean LOS in England, Northern Ireland and Wales was 19.3, 22.4 and 35.2 days, respectively. Explanations for this variation may lie outside hospitals, with variable access to intermediate care, supported hospital discharge and social care. Moreover, we should beware of pushing for ever shorter LOS, as Scandinavian data suggest that early discharge (at least within the range of LOS up to 10 days) may be associated with an increased risk of early mortality [6].

The National Osteoporosis Society, Royal College of Physicians and Royal College of Surgeons have strongly advocated the development of orthogeriatric and fracture liaison services. While previous studies have shown that both orthogeriatric [7] and multidisciplinary [8] models of care appear to be cost-effective, Dr Hawley et al. [9] present data in this edition of Age and Ageing looking at the effects of introducing these models of care in a real world setting, using routine Hospital Episode Statistics (HES) data. The authors assessed the impact of the introduction or expansion of orthogeriatric and nurse-led fracture liaison service models on post hip fracture mortality and second hip fracture in 33,152 hip fracture patients from 11 acute hospitals. Orthogeriatric and nurse-led FLS were associated with improved 30-day and 1-year mortality of around 15–30%, although there was no significant impact on time to second hip fracture (after 2 years of monitoring). These results give no clear evidence on the best model of care and it is little disappointing that they do not present data on LOS, as a decrease would add to a health economic argument for these services.

While it is important to target the health cost of acute management and rehabilitation, secondary prevention, including falls assessment, and the prescribing of drugs to treat osteoporosis are important components of any package of care. With previous studies seeing second hip fractures in 2–3% patients per annum and 10% of patients overall [10–12], follow-up for just 2 years was unlikely to show any effect of pharmacological intervention, although more immediate effects of fall and fracture prevention might have been anticipated. Nationally, the most recent NHFD data show rates of osteoporosis assessment and bone protection prescription of 80.1% and falls assessments performed in 96.1% of patients. Evidence that this results in a decrease in second hip fractures would have also been welcome. However, gathering evidence on such a complex intervention was a difficult challenge, potentially compounded (and confounded) by background noise from the NHFD and BPT, for which there is growing national evidence of some benefit. It is reassuring to see the study results map to the national picture provided by data from the NHFD and, as arguments for cuts to health care...
budgets may be anticipated in the NHS over the next few years, evidence that mortality is so significantly decreased by simple service developments will be crucial in protecting them in the future!

**Key points**

- The introduction of Orthogeriatric care and Fracture Liaison Services (FLS) has been associated with decreased mortality 1 month and 1 year after hip fracture.
- Unfortunately, we have no clear evidence for the best model of care (orthogeriatric or FLS).
- The introduction of the National Hip Fracture Database, BPT and the BGS/BOA ‘Blue Book’ has probably contributed to an improvement in outcome.
- Early placement on a surgical ward with prompt MDT assessment and timely surgery results in better outcomes.
- Evidence for medical intervention to reduce risk in second hip fractures up to 2 years is disappointing.

**Conflicts of interest**

None declared.

BELGIN OZALP¹, TERRY J. ASPRAY¹,²

¹Musculoskeletal Unit, Freeman Hospital, Newcastle upon Tyne, UK
²Institute for Cellular Medicine, Newcastle University, Newcastle upon Tyne, UK

Address correspondence to: T. J. Aspray. Tel: (+44) 191 213 7975; Fax: (+44) 191 223 1291. Email: T.J.Aspray@newcastle.ac.uk

**References**


Pharmacists and prevention of inappropriate prescribing in hospital

The art of prescribing for older people depends not so much on merely knowing when drugs are indicated for certain conditions, as knowing when they are appropriate, particularly in the context of multi-morbidity. The presence of potentially inappropriate medications (PIMs) is a highly prevalent problem among older people in hospital [1]. Equally common are potential prescribing omissions (PPOs), that is, instances of potentially inappropriate omission of potentially beneficial medications that are indicated but omitted for irrational or ageist reasons [2]. Data from hospitalised older people indicate that