British Orthopaedic Association

Multi-Disciplinary Clinical Service Review: Care of Patients with Non-Ambulatory Fragility Fractures

Organising the Review

Preparing for the Site Visit

Lay Representative

The organisation should nominate a lay representative, usually a Non-Executive Director, to join the review panel. The lay representative is an integral member of the review panel and is expected to be present for the whole of the site visit, including the evening discussion between the two days of the visit. The lay representative is vitally important to provide to provide a patient-centred view, local context and insight into the culture of the organisation for the external reviewers and Board-level support for implementation of recommendations and change in practice once the review is completed. If a Non-Executive Director is not available, the organisation may suggest an alternative lay representative but will need to outline to the BOA how these three essential roles will be achieved by that individual.

Any payment or compensation for the lay representative should be paid directly by your organisation in line with your usual policy. Any data the lay representative is provided with as part of the review must be handled confidentially in line with your organisation's relevant confidentiality agreements and processes.

Details of the nominated lay representative should be sent to the BOA by the operational lead contact a minimum of **four weeks** before the date of the site visit

Pre-Visit Information

The review panel do considerable preparation in advance of the site visit. This includes review of publicly-available information from the NHFD. We also ask for details of the facilities, resources, pathways and policies currently in place in the organisation along with any local audit data.

We strongly recommend that, prior to a review, the team at the site, led by the NHFD clinical leads, interrogates their NHFD data and aims to consolidate any quality improvement initiatives that have already taken place. Our experience is that, by the time of the site review, positive changes have often been made already.

The completed pre-visit questionnaire and all relevant documentation should be returned to policy@boa.ac.uk by the clinical lead contact a minimum of **four weeks** prior to the agreed date of the site visit for dissemination to the review panel.

Facilities

The operational lead contact is responsible for ensuring that suitable facilities are available for the review panel and staff attending meetings. There will usually be seven people on the review panel.

The review is chaired by an orthopaedic surgeon, with four additional clinical representatives from orthopaedics, anaesthetics, orthogeriatrics and nursing, along with a review manager and the nominated lay representative. Any variation from this will be advised by the BOA team who will confirm the names of individuals of the external reviewers in advance of the site visit.

Contact Person

Please ensure that the BOA team have reliable telephone contact details for a named individual to act a consistent named contact person for the duration of the review. These details will be disseminated to all review panel members.

Parking

Please arrange parking for any members of the review team who plan to drive to the site; the BOA team will confirm names and registration numbers if required.

Site Facilities

Please arrange booking of an appropriate lockable room to seat a minimum of twelve people for the review panel to use for the afternoon of the first day of the visit and the morning of the second day. This should be in a convenient location for staff on site who will potentially be interrupting clinical work to attend the meetings. The room should include relevant AV equipment for the review panel to use, including a large screen or projector and adequate charging points. Please ensure that wi-fi access, including any relevant access code, is available for the review panel.

Face to face meetings are encouraged unless unanticipated infection control measures at the organisation preclude this. If some members of the team are unable to join a face to face meeting, remote access may be considered (e.g. via MS Teams) but we ask you to liaise with the BOA in advance. If remote access is planned, please ensure that appropriate IT support is available to set up and check that the system is working correctly before the meetings begin.

Refreshments

The review panel members have usually travelled some distance to the site and we ask you to provide a sandwich lunch for the review team on arrival. Please also provide tea & coffee at a break during the afternoon of the first day and the morning of the second day.

Accommodation

Please organise bookings at a local hotel with dinner, bed and breakfast for the review panel for the night between the two days of the site visit. You should liaise directly with the nominated lay representative about whether they require accommodation.

Details of the named contact person, directions to the hospital and parking, location of the on-site room for the review panel, and hotel bookings with directions should be provided to the BOA by the operational lead contact a minimum of **two weeks** before the site visit.

Meetings with Key Individuals

Responsibility for organisation of the meetings with key staff members lies with the operational lead contact with support from the clinical lead contact. The BOA team will liaise with those individuals and the BOA Trauma Committee Review Lead and/ or the Review Panel Chair are happy to discuss any clinical questions that the administrative team cannot answer.

The provisional timetable below should act as a guide to arrange for relevant staff to attend the meetings on the first afternoon at suitable times. A full timetable with names and roles of all

attendees should be returned to the BOA by the operational lead contact a minimum of **two weeks** before the site visit.

In advance of the review visit, please ensure that all staff attending the meetings have confirmed their attendance, have been made aware of the terms of reference for the review and have access to any documentation provided by the BOA.

Key Staff Groups

During the afternoon of the first day, the panel meet with key individuals from the multi-disciplinary team to discuss current pathways of care, data and any concerns or barriers to improvement that the teams wish to raise. The key staff groups include doctors, nursing, therapy and allied staff from all areas that play a major role in care of this patient group within the hospital. This should include the clinical leads for the NHFD.

The panel try to meet staff from a wide variety of backgrounds and welcome suggestions from the organisation for additional individuals who may play a key role on that site. It may be appropriate to combine some staff groups depending on job roles. At minimum, we need to speak to:

- Emergency Department consultant & nursing representative
- Trauma & Orthopaedics NAFF lead +/- clinical director
- Anaesthetic lead for NAFF +/- clinical director & theatre staff
- Orthogeriatrician responsible for care of patients with NAFFs
- Nursing representatives, including senior nurse for trauma wards, specialist nurses or advanced practitioners involved in care of patients with NAFFs, trauma coordinators etc.
- Therapy and discharge planning teams
- NHFD leads and individuals involved in data collection
- Service and business managers

Provisional Timetable

<u>Day 1</u>

13.00 – 13.30	Meeting of review team to discuss the programme and information received from the organisation.
13.30 – 14.00	Meeting with clinical and operational lead contacts to discuss the review process. The commissioning executive or deputy, senior leaders from the organisation and some senior clinical staff may wish to attend this, although the total number of people should remain relatively small.
14.00 – 18.00	Meetings with key staff groups as outlined above. There is no particular order in which the panel prefer to see individuals and this session can be fairly flexible so please schedule meetings around clinical commitments as appropriate. We suggest that each session is between twenty and thirty minutes long but please ensure that a short coffee break is scheduled for the review panel approximately half way through the afternoon.

<u>Day 2</u>

08.00 – 10.30	The review panel will join the morning trauma meeting. The panel will then divide and follow the patient's journey through the site, with visits to the Emergency Department, theatres, trauma wards, etc. They will meet informally with patients and other staff. Please ensure that individuals are allocated to

accompany or direct at least two separate groups of panel members and that they are able to access the relevant areas.

10.30 – 11.45 Return to the booked room for tea/ coffee break and to discuss findings, recommendations and immediate feedback.

11.45 – 12.00 Meeting with clinical teams to discuss findings and check that there are no major gaps in understanding. If a larger group wish to attend this meeting, a room with sufficient space or remote access should be arranged.

12.00 – 12.30 Meeting with commissioning executive, clinical teams and senior leadership for initial feedback, including themes of findings and any immediate safety concerns.

The BOA acknowledges that participation in the review is a voluntary process and that staff are not compelled to take part. However, we hope that all relevant personnel will recognise the supportive nature of the review and will be happy to contribute. In the event that an individual or individuals are not willing to participate in the review, we would expect the organisation to decide whether the review was still feasible and to take appropriate steps to ensure that any patient safety risks are addressed, notifying the relevant Responsible Officer and taking advice from regulatory bodies as required.

What should your team expect during the site visit?

The primary aim of the review is to appraise patient care against nationally published standards and guidance for patients with non-ambulatory fragility fractures (NAFFs) and to produce recommendations that will help the clinical and operational teams to drive improvement in the quality of the care they provide. The review is designed as a supportive process to help staff deliver high quality care for these patients; it is not an inspection and the review team act as critical friends, not as regulators. We hope to develop a constructive and supportive relationship with staff at the site throughout the process.

Reviews are always at the request of the organisation itself. Often, the request is made because 30-day mortality has been recorded as high in the NHFD data. However, this does not mean that care is universally poor and, for instance, may be the result of inaccurate data entry by the site. Even if the team feel that there are elements of care that could improve, there will also be areas of good care and innovation. Our experience is that reviews are invariably requested by organisations and teams who want to provide excellent care. The reviews do not specifically seek to answer the question “why is our mortality high?”; rather we look for areas where care could be delivered more effectively and with greater impact, leading to a reduction in mortality as a secondary outcome. All discussions with staff are “fact-finding”; we are not looking to find fault or apportion blame.

The review panel try to meet as many people as possible in two main settings. On the first afternoon, we have a series of meetings with key individuals from all the different groups of staff involved with care of these patients. There is no set number of people per specialty but generally it is in small groups of two to four people and each session is for twenty to thirty minutes. We try to keep to time as far as possible but our experience is that people usually have a lot that they want to tell us. The following day, we meet a wider variety of people as we walk through the patient journey, visiting the Emergency Department, theatres and wards. It is helpful if people in those areas are already aware that we will be walking around and are encouraged to contribute to the process. This often includes more junior members of staff. We also try to speak to patients or relatives if possible.

We do not expect the individuals we meet to have made any specific preparation for the meetings. However, it is most useful if the people we see in the meetings are directly involved in care of patients with NAFFs and are familiar with both the day to day working of the team, the data collected nationally and any local audit data. In general, teams will usually be asked about their role in care of patients with NAFFs and to describe what they think works well already and where they think there is room for improvement. The review panel may ask targeted questions on the basis of the information provided in the pre-visit documentation and the data in the NHFD. All members of staff involved in the review should be made aware that there are no right or wrong answers to any of the questions. We aim to gain a good understanding of current processes, how the team envisage improving care and any perceived barriers to progress.

Traditionally data collection for NHFD and Best Practice Tariff was aimed at the narrow group of patients with “hip fractures” and our experience is that care pathways evolved to target this particular patient group. There is increasing recognition that all frail older patients with NAFFs have similar care needs and the review will focus on this broader group. Teams should be aware that the remit of the review will not only be on patients with “hip fractures” but will include most older and frail patients who are admitted to hospital with lower limb fractures and those with upper limb fractures that disrupt mobility, for example in patients who rely on walking aids. They may be asked if there are differences in pathways for similar patients with different injuries.

Informal initial feedback will be given at the end of the site visit. We aim to produce a report that is constructive and can be widely shared. Individual members of staff are not named, other than as a record of who we spoke to in the formal meetings, and there is no attribution of specific comments to identifiable individuals.