

Fall and bone health management assessment proforma:

Improving care across primary and secondary care

Provided by: **University Hospitals of Leicester NHS Trust**

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Sharing QIPP practice: What are 'Proposed Quality and Productivity' examples?

QIPP Evidence provides users with practical case studies that address the quality and productivity challenge in health and social care. All examples submitted are evaluated by NICE. This evaluation is based on the degree to which the initiative meets the QIPP criteria of savings, quality, evidence and implementability.

Proposed quality and productivity examples are those predominantly local case studies that meet most of the criteria but lack evidence of impact following implementation. This may be because they are at an early stage of implementation and further evidence is forthcoming. These proposed examples may be of interest, prior to the addition of further information which will be sought within a year period from the point of publication. A summary of findings is provided below along with comments and recommendations about how this case study may be developed.

Overview

This case study aims to reduce community falls and improve bone health management among the elderly population by improving information and knowledge transfer between primary and secondary care through the use of a specialised geriatric assessment proforma. The initiative aims to prevent hospital re-attendance, hospital readmission and reduce length of hospital stay for this group of patients.

NICE comment

The anticipated savings will be cash releasing as the initiative aims to reduce hospital admissions. Income to the provider will be reduced but resources will be freed up for other duties. To put the savings into context, each avoided hip fracture saves £25,000, which will fund 142 visits to a falls clinic. The success of the initiative is dependent on collaborative working across primary and secondary care and the successful uptake of the geriatric assessment proforma.

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Details of initiative

Purpose	To improve bone health and falls management, prevent readmissions and reduce the length of hospital stay for older people. This will be achieved by improving information and knowledge transfer between primary and secondary care using a specialised geriatric assessment proforma.
Description (including scope)	<p>This initiative aims to identify people at risk of functional decline, readmission and death by implementing a proforma incorporating the validated Identification of Seniors at Risk (ISAR) tool (McCusker et al. 1999). The key objectives are to:</p> <ul style="list-style-type: none">• increase prescribing of osteoporosis medication in the community• increase general practitioner (GP) referrals to underutilised community falls services• decrease rates of acute medical readmissions for frail older people• increase referrals to community services for a multi-factorial falls risk assessment (therapy)• improve staff and patient satisfaction with assessment and management of falls• decrease admission rates for older people presenting with falls by improving community management. <p>Face-to-face contact in the emergency department (ED) can help identify people who are either at risk of future falls or those who have not informed their GP of any history of falls. Sharing this information with GPs can help earlier engagement with community-based services, which may help to prevent falls and fractures in the future.</p> <p>The initiative focuses on all patients over 70 who:</p> <ul style="list-style-type: none">• attend the ED of the Leicester Royal Infirmary (LRI)• are discharged from the ED after treatment and management to the care of their own GPs• are referred to the fracture clinic. <p>The initiative does not include:</p> <ul style="list-style-type: none">• patients admitted to the LRI or transferred to any community hospital• patients under the age of 70.
Topic	Acute/urgent care, primary care, right care and medicines management.
Other information	In England, over the next 20 years, the number of people aged 85 and over is set to increase by two-thirds compared with a 10%

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growth in the overall population (Wanless 2006). Optimising the management of older people in urgent and emergency care will be a major challenge.

Older people currently make up 17% of ED attendances at the University Hospitals of Leicestershire (UHL) NHS Trust. This includes 6500 people who have had a fall and 750 people with hip fractures each year. A total of 71% of people aged over 75 are admitted to hospital after attendance at the ED. They account for 50% of acute medical admissions, and once admitted, the median length of stay is 9 days.

The National Falls Audit (2011) revealed that, despite clinical evidence in favour of managing falls and bone health, the provision of care is very poor. Although cost effectiveness data on preventing falls with the aim of reducing hip fractures are not available, as a public health intervention, in the absence of health education and preventive medicine, it is most likely unaffordable.

[The following documents were provided to support the proposed initiative:

- *a carbon impact assessment*
 - *a project initiation document*
 - *a study summary*
 - *an ED nurse assessment form].*
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Gate 1: Savings anticipated

Amount of savings anticipated	Anticipated savings are £100,000 for a population of 961,500 or £10,400 per 100,000 population.
Type of saving	The savings will be cash releasing because there will be a reduction in admissions. Income to the provider will be reduced but resources will be freed up for other duties. To put the savings into context, each avoided hip fracture saves £25,000, which will fund 142 visits to a falls clinic.
Any costs required to achieve the savings	The initiative has non-recurrent funding of £50,000 per year for 2 years to fund staff to support implementation. This pays for the project coordinator post. The initiative uses a diffusion of innovations model. The project coordinator goes out to every GP practice and walk-in centre/minor injury unit to discuss ways of improving falls management. Minimal associated costs over 2 years include travel and start up of information management and technology (IM&T) processes (approximately £2000).
Programme budget	The initiative has funding for 2 years from the NHS Regional Innovation Fund (January 2011–December 2012).
Details supporting Gate 1	Referrals to community falls programmes are anticipated to increase but have not been entered as a negative impact

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because, based on actual referral figures from GPs and multidisciplinary team resource availability, the service is currently considered to be 'underutilised'.

Prescribing medication for osteoporosis and bone health is anticipated to increase, however the cost may be offset by other medication reviews and reductions. These costs cannot be estimated and given the amount of medicines management that actually takes place on a daily basis in primary care, it is virtually impossible to calculate this figure across 140 GP surgeries with 600 GPs in Leicester, Leicestershire and Rutland (LLR).

Gate 2: Quality outcomes anticipated

Impact on care quality	Clinical outcomes for patients should improve through the identification and better management of those at risk of falls.
Impact on patients, people who use services and community safety	The initiative is anticipated to improve patient safety by preventing falls.
Impact on patients, people who use services, carer, public and community experience	Patient and carer experience is expected to improve as a result of better communication between primary and secondary care and the patient or carer. This will also lead to the provision of care closer to the patient's home.
Supporting evidence	This initiative started in January 2011 and therefore no local data are available yet. Expected outcomes are: <ul style="list-style-type: none">• increased referrals to community falls service• increased prescribing of vitamin D3 and calcium• reduced admissions through EDs after patient falls.

Gate 3: Evidence of effectiveness

Evidence base for initiative	The initiative is based on: <ul style="list-style-type: none">• The assessment and prevention of falls in older people. NICE clinical guideline 21 (2004).• Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fractures in postmenopausal women. NICE technology appraisal guidance 161 (2005).• Other published literature.
Evidence of deliverable from implementation	Evidence of implementation is not yet available because the project began in January 2011 and GP engagement started in April 2011. The initiative was started in the ED and has three stages as follows:

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- Completion of a standardised **geriatric assessment proforma**, which includes the validated ISAR screening tool to help identify patients at risk of future falls. Patients aged over 70 who are discharged to the care of their GP after treatment or a fracture clinic referral will have recommendations for primary care interventions suggested on a tailored discharge letter.
- The **tailored discharge letter** has tick-box recommendations for various interventions including:
 - referral to community falls services
 - prescribing calcium and vitamin D3
 - reviewing all medications, including anticoagulants.
 - referral for visual assessment
 - reviewing long-term conditions or end-of-life care plans
 - referral to social services, if appropriate.
- **Informing** over 140 GPs in Leicester and Leicestershire of the changes at practice level, by face-to-face contact and a brief PowerPoint presentation on the value of the ISAR screening tool and associated falls/bone health management.

After successful implementation of a pilot study in UHL, the initiative has been extended to LLR.

Supporting evidence for Gate 3

Any evidence of effectiveness will not be seen until the end of the initiative in December 2012.

Gate 4: Feasibility of implementation

Implementation details

The initiative will be implemented in a similar way to the pilot study.

Key to implementation is rollout and use of the specialised geriatric assessment proforma, which includes the ISAR and a risk stratification tool for falls and bone health.

The co-ordinator will provide support to the project by:

- spending time in the ED supporting the staff to improve completion of the proforma
- helping to circulate the proforma and the actions stemming from this in local GP practices
- encouraging the sharing of the proforma with the fracture clinic to aid liaison
- liaising with the fracture clinic matrons about older patients referred with fragility fractures.

Time taken to implement

Implementation can be achieved in 1–3 years.

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Ease of implementation

The project affects multiple organisations, involving multi-agency working.

An educational package based on knowledge transfer principles and incorporating the ISAR score and NICE clinical guideline 21 will be developed with input from Collaboration for Leadership in Applied Health Research and Care (CLAHRC) and the Royal College of Physicians (RCP) to help distribute the learning package. It is anticipated that the educational package will take 1 day to produce after input from experts in the field.

This package will include a set of slides to be used when communicating with GPs and will also be available on the CLAHRC website. It will be a one-off presentation, taking approximately 15 minutes, and there will also be online slides for ongoing referral.

Level of support and commitment

A follow-up survey and audit of the pilot study revealed that 50% of doctors and 78% of nurses were completing the forms, but 20% of the staff surveyed did not believe that older patients needed any tailored assessment. There were also issues around sharing information with primary care colleagues, primarily because ISAR is not a familiar tool in the UK.

Barriers to implementation

Potential barriers to implementation are:

- recruitment and retention of willing GP practices
- health professional awareness and support of the initiative
- funding
- ensuring the quarterly rotation of ED doctors keep gathering the information and then persuading GPs to act on it.

Risks

Potential risks and challenges are:

- recruitment and training timescales
- inability to engage with GPs
- GPs not taking up the initiative
- working across services
- lack of awareness of the ISAR tool
- managing identified need to ensure efficient delivery of a quality service.

Supporting evidence for Gate 4

No additional information provided.

Further evidence

Dependencies

The success of the initiative is dependent on the support of health professionals in the primary and secondary care settings.

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Contacts and resources

Contacts and resources

If you require any further information please email: contactus@evidence.nhs.uk and we will forward your enquiry and contact details to the provider of this case study. Please quote QIPP reference 11/0015 in your email.

McCusker J, Bellavance F, Cardin S et al. (1999) Detection of older people at increased risk of adverse health outcomes after an emergency visit: the ISAR screening tool. *Journal of the American Geriatrics Society* 47(10): 1229–37.

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Related reading

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