

# Improving the quality of the pathway for over 65 year olds who fall with injury in Southampton City

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BACKGROUND  
AIM  
METHODS  
MEASURES

Falls and fractures in older people lead to injury, loss of independence and mortality.

Emergency hospital admissions for injury due to falls for over 65 year olds in Southampton are significantly higher than the England average. In 2016-17, Southampton City CCG had the 6<sup>th</sup> worst rate of emergency admissions in the country, higher than all comparator CCGs.

To reduce the number of emergency admissions for falls with injury in over 65 year olds in Southampton

- Data analysis
- Stakeholder workshop
- Falls Quality Improvement plan focused around 5 key areas led and delivered by a multi agency group
- PDSA cycles focused on Fracture Liaison Service

**Outcome:**

- Number of non-elective hospital admission for falls with injury in over 65 year olds

**Process:**

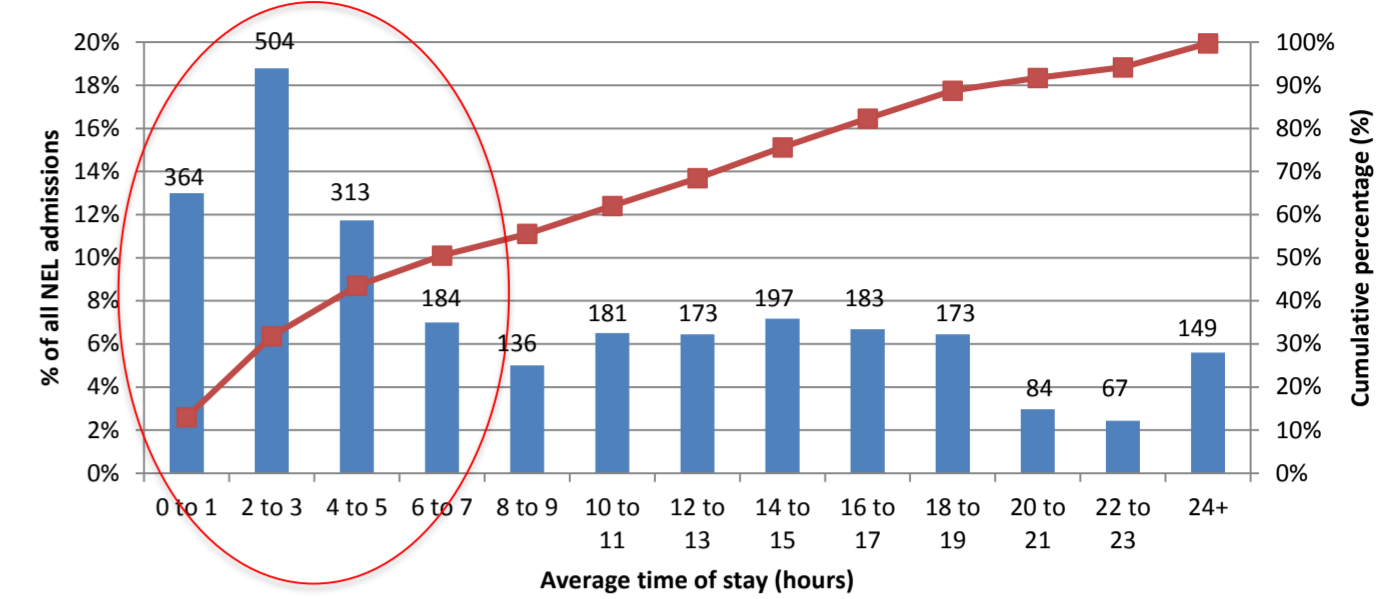
- Number of admissions staying less than 6 hours
- Effective, timely identification of fragility fractures
- Number of people on bone health medication
- Increased uptake of falls exercise

## IDENTIFYING THE PROBLEM

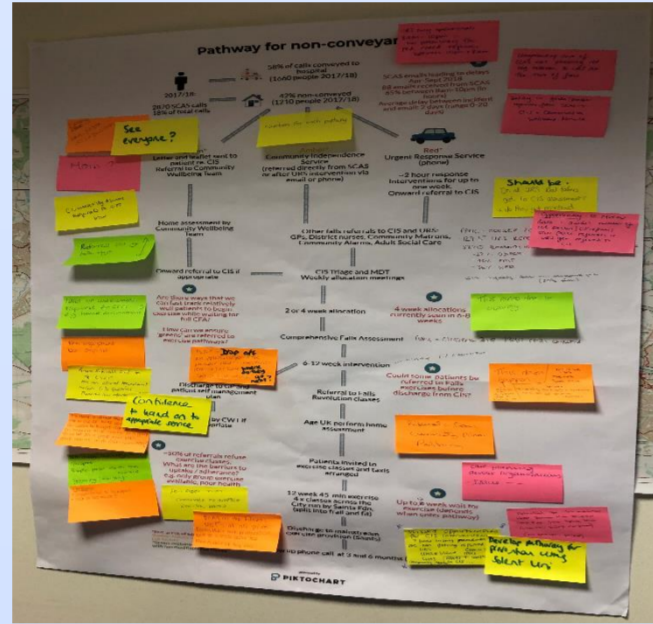
An important objective of this work was to identify drivers for variation to inform local action for people working across the falls pathway. Data analysis from 2015-19 showed that:

- 83% of people fall in their own home
- Highest number of ambulance calls were between 8am and 1pm
- 40% of 999 calls are not conveyed
- Of those conveyed and admitted, 60% stayed less than one day; 50% of these stayed less than 6 hours
- 75% of people had an X-ray but only 30% fractured

Average length of stay for short stay NEL admissions (0-1 days) 2015-19

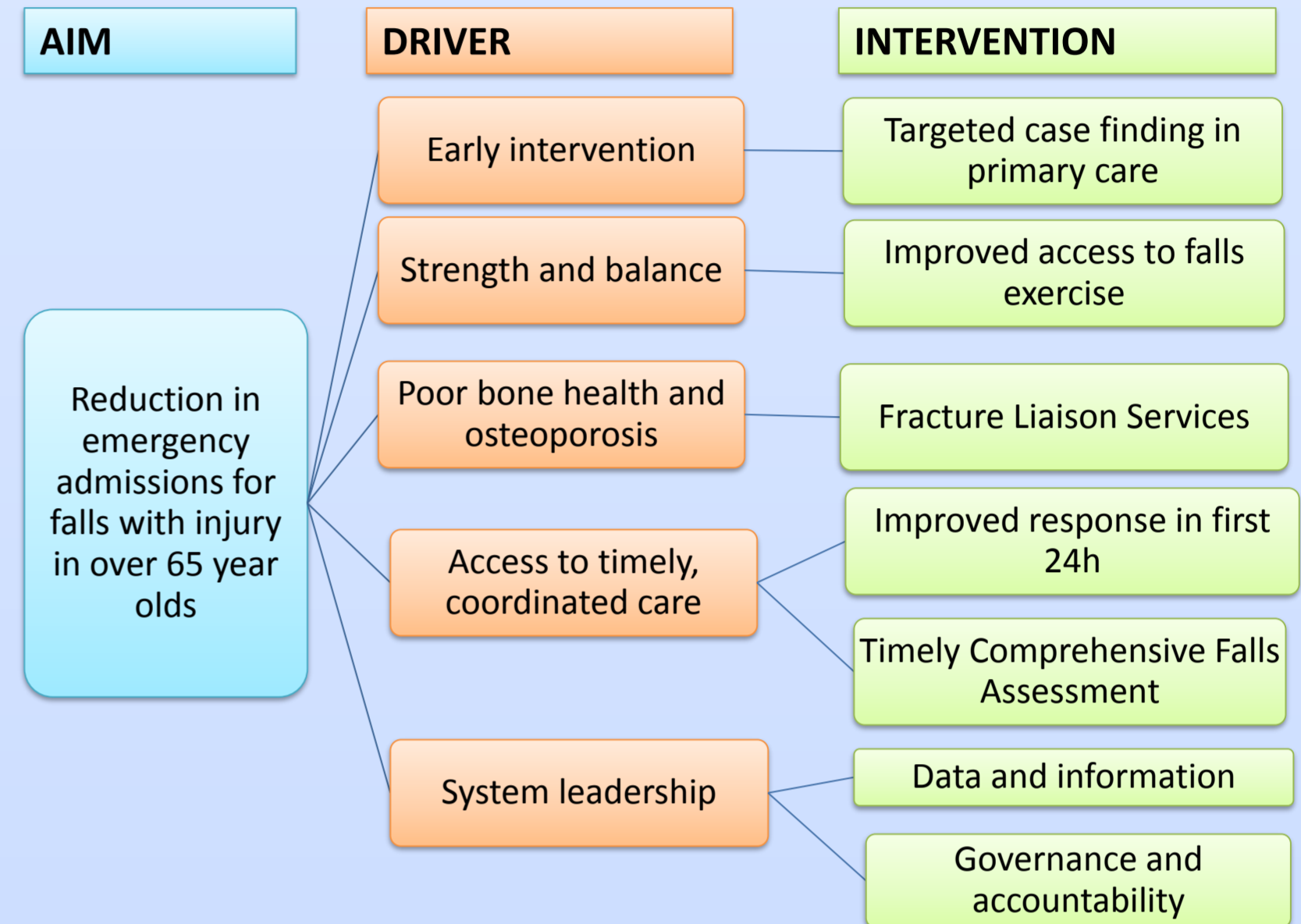


## FINDING SOLUTIONS



A stakeholder workshop with commissioners, service providers and clinicians from across the falls pathway was held:

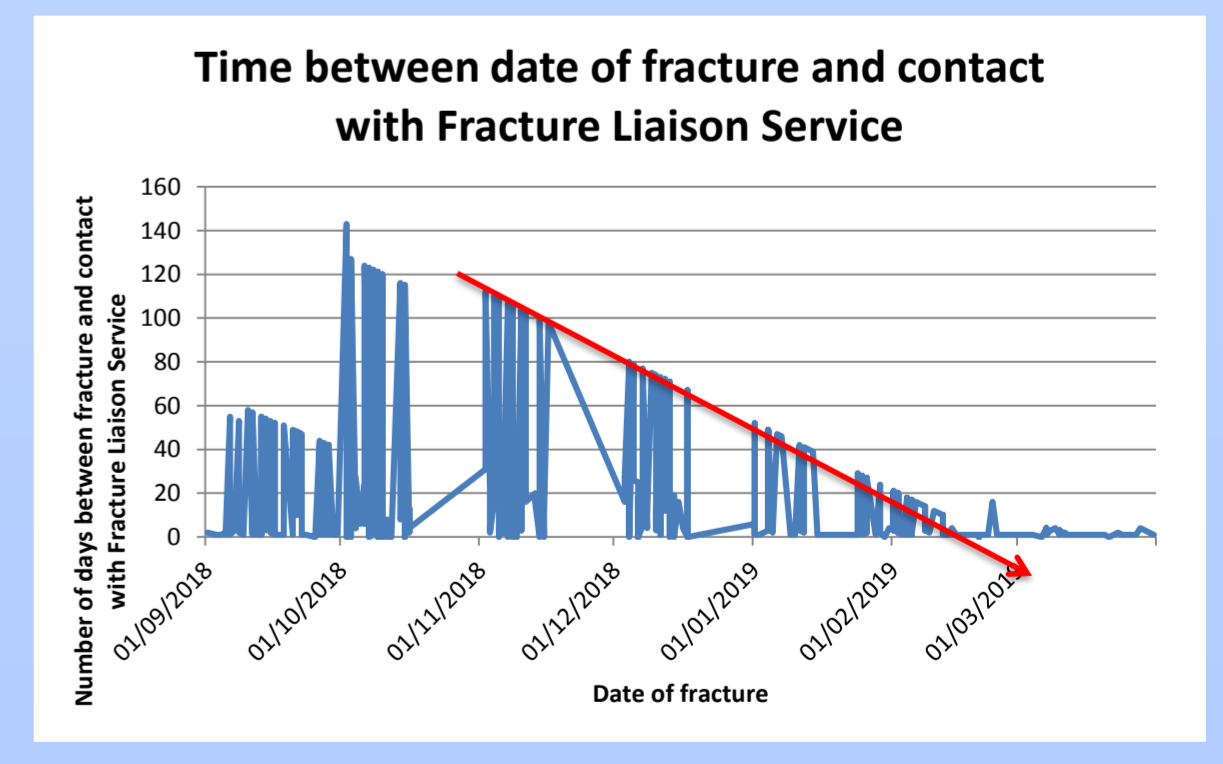
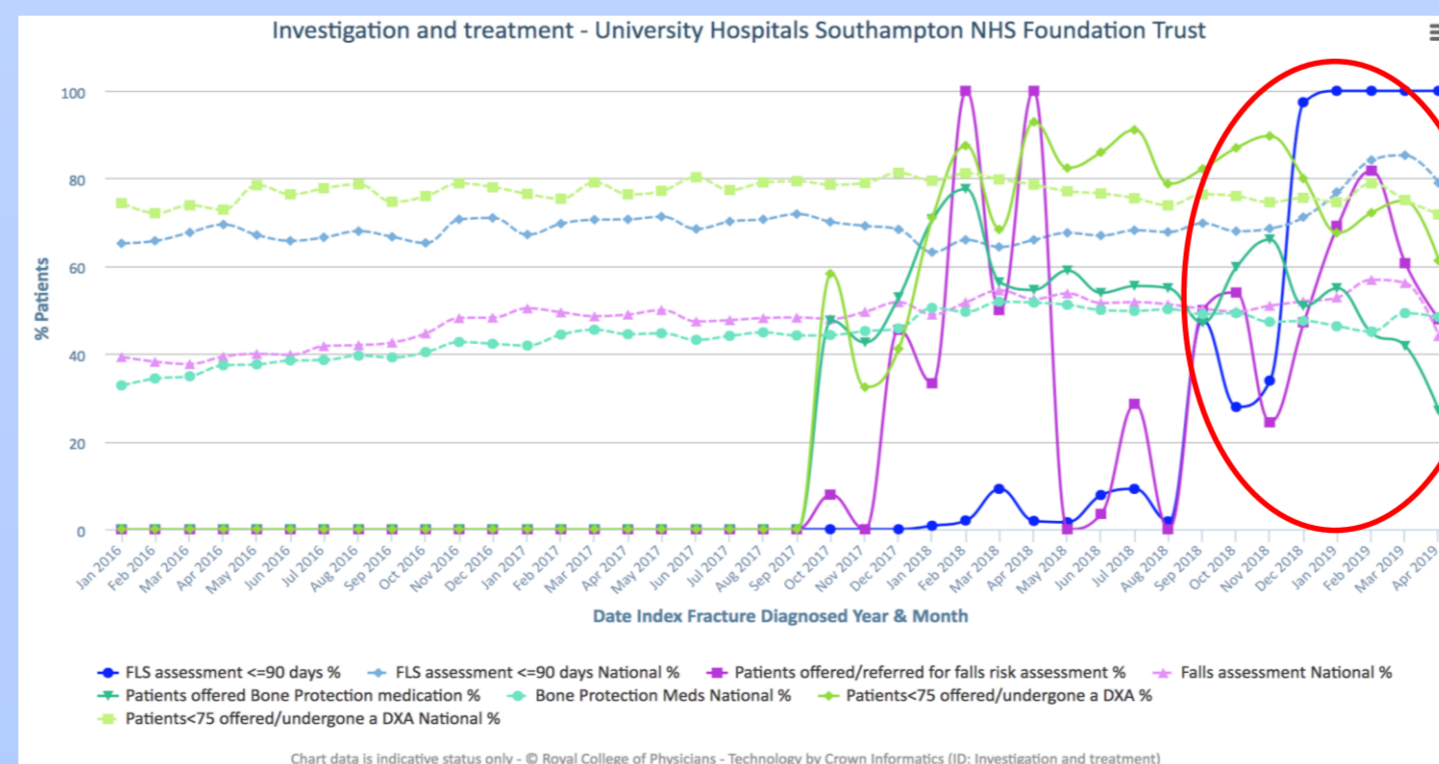
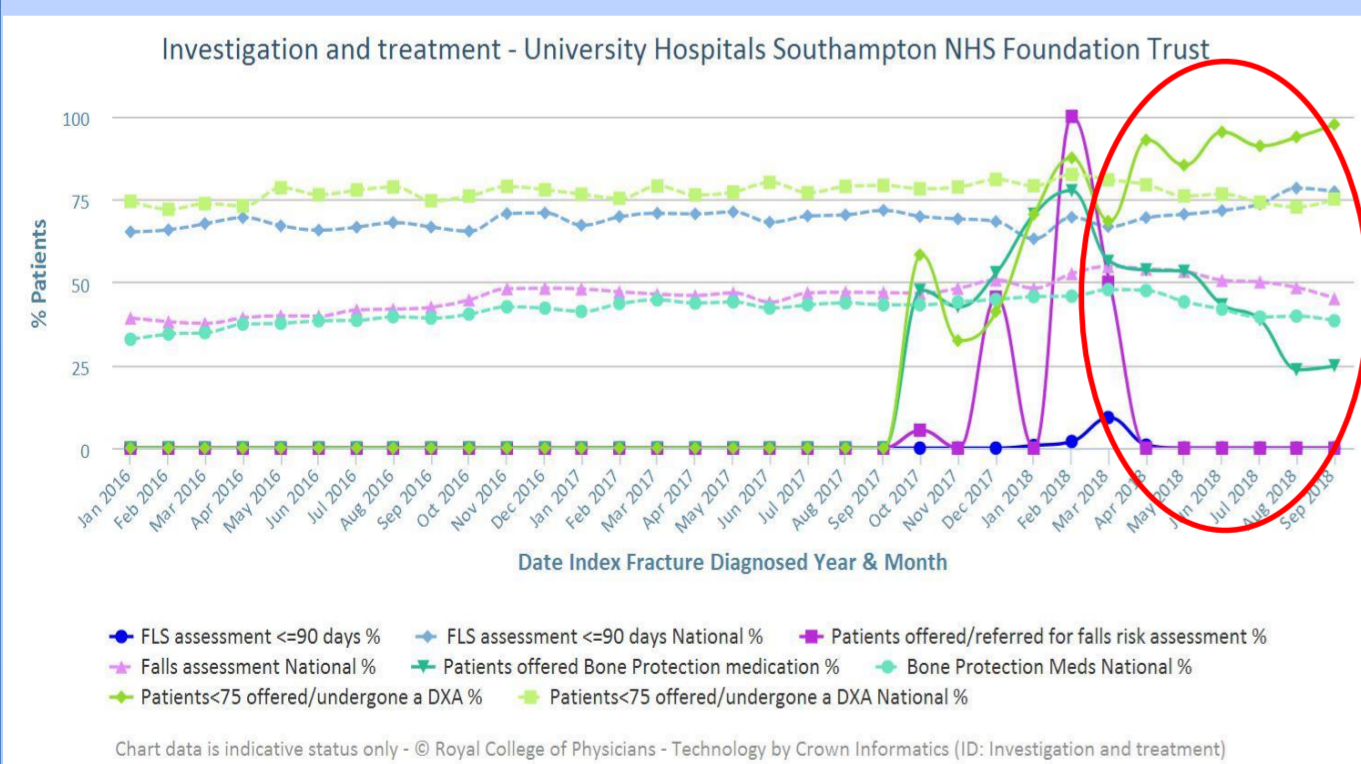
- Providing narrative to the data
- Mapping patient pathways
- Identifying bottlenecks, challenges and issues
- Collectively setting priorities



## ACTIONS: FALLS QUALITY IMPROVEMENT PLAN

- Targeted case finding**
  - 3 practices piloting identification of fallers from GP lists using Keele University tool.
  - Patients identified then followed up using different models: Community Wellbeing Team, physios and exercise instructors to enable early intervention and reduce future falls risk.
- Improved response in first 24h**
  - Increased access to Telecare through free trial service.
  - Dedicated clinician on ambulance call out desk.
  - Increased investment in workforce to support more timely Comprehensive Falls Assessments.
- Fracture Liaison Service**
  - Developing pathway for effective identification and management of over 50 year olds with a fragility fracture.
  - Improved case finding, data capture and recording, Standard Operating Procedure established, links to patient support, management and oversight.
- Falls exercise**
  - Identification of barriers to uptake fed back into the service to improve offer.
- System leadership**
  - Falls dashboard summarising data across falls pathway over time: measuring impact and monitoring trends.
  - Governance structures established linked to Better Care.
  - Integration of falls and frailty workstreams to enable coordinated care in the longer term.

## RESULTS: FRACTURE LIAISON SERVICE



### Achievements

- Backlogs within hospital and Community Wellbeing Team cleared and more patients seen
- 97% of patients (n=298/306) recorded as having a Fracture Liaison Service assessment less than 90 days after date of fracture (August 2018: 1% n=1/99)
- 60% of patients (n=184) offered or referred for falls risk assessment (August 2018: 50%, n=49)
- Task and finish group set up: improved communication, ongoing quality improvement

### Challenges

- Service reliant on small number of people for delivery
  - Lack of continuity
  - Batching of workloads
- Delays in recruitment: functioning below capacity
- Pathway delivered by different providers
  - Communication, consistency, competing priorities

## LESSONS LEARNT

- **Maintaining communication:** Quality Improvement process has supported different parts of the system to talk to each other. Task and finish group will sustain this.
- **Involving people from across the pathway at each stage** means changes made and structures set up will carry on over time; leadership is key from across the system.
- **Sustainable, system-level change can be slow progress:** lead in time for many of the actions means results not expected until 2020. CCG and Public Health will continue to lead work.
- **Competing priorities present a challenge:** ongoing work to create simplified, coordinated pathways of care flexible to people's needs