



Commissioning, implementation and delivery of an interface secondary fracture prevention service within the NHS: Lessons learnt from the Oxfordshire Fracture Prevention Service

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KEYWORDS

Fracture prevention;
Osteoporosis;
Hip fracture;
Secondary prevention;
Adherence

Abstract Aims: To provide a case history of the service model, commissioning, implementation and delivery of an interface secondary fracture prevention service.

Background: Fracture Prevention has been identified as key to reducing the burden on the NHS from an ageing population. The need to have a systematic process for identifying, assessing and ensuring treatment adherence is vital.

Rationale: Delivering the service to identify patients at risk and initiate treatment is important as is the use of a database for patient tracking and the need to ensure that patients remain on treatment to ensure maximum fracture prevention benefit, and cost savings are seen. The process for implementing a Fracture Prevention service can be challenging but identifying the components and working closely with local commissioners can provide the evidence and release the resource required.

Summary: The key components of a Fracture Prevention Service should include robust case-finding, assessment, treatment initiation, patient education and monitoring.

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Editor comments

Service development is central to improvement of care delivery. Fragility fracture is providing significant challenges as numbers increase around the globe. This paper explores the implementation of a fracture liaison service in one locality aimed at reducing the number of fractures. Not only might this assist others in planning and implementation of similar services but highlights the importance of funding and organisational commitment to the new service and its potential benefits.

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Background

Fragility fractures are a growing challenge for patients, clinicians, the NHS (National Health Service) and society. Epidemiological studies have highlighted the importance of targeting those presenting with an incident fragility fracture (Kanis et al., 2004). These patients are at the highest risk of further fracture and a number of landmark trials have established that the effective use of pharmacological therapies reduces the risk of fracture (Murad et al., 2012). Despite this, national audits have consistently demonstrated poor rates of secondary fracture prevention in primary (25% Quality outcome Framework (QOF) 2012/3) and secondary care (32% Royal College of Physicians (RCP) Audit 2011) (Tremblay et al., 2011). While dedicated fracture liaison services are currently recommended nationally (Department of Health, 2009) and internationally (Marsh et al., 2011) there is little pragmatic evidence for how to implement them within an NHS setting (Clunie and Stephenson, 2008).

The aim of this study was to provide a case history of the service model, commissioning, implementation and delivery of an interface secondary fracture prevention service.

Rationale for the selected service model

To realise the benefits of secondary prevention requires effective case-finding, evidence-based assessment with treatment recommendations and then support for medication adherence (Newman, 2011). Given that 12% of individuals who sustain a fragility fracture will re-fracture within 24 months (Johnell et al., 2004), the potential effectiveness of a service is critically dependent on the success of this pathway, with particular attention to case-finding and adherence. It is estimated that up to 30% of the fractures prevented will be at the femoral neck (Akesson et al., 2013; Marsh et al., 2011).

Overall strategy

As we were combining both bone health and fall reduction and also aiming to improve patient understanding, we used the title of Fracture Prevention Service (FPS). The rationale behind this was that patients did not readily understand what a liaison service offered. There was also a requirement to provide a truly holistic service with some fall prevention included. We aimed to case-find all patients aged 50 yrs or older presenting with an acute fragility fracture to the local secondary care hospitals. A fragility fracture was identified as an injury sustained from a fall of less than 6 feet. Patients with fractures of the digits, scaphoid, face and skull were excluded. The development of a pathway for case-finding radiographic vertebral fractures was initially postponed.

Locality details

The service is county-wide and covers two acute hospital settings. Hospital A is a major trauma centre and admits 600 hip fractures a year to two inpatient wards. All patients presenting with a fracture to the Emergency Department and not admitted are routinely seen in the 'new fracture' clinic the next day, seven days a week. In addition, patients are followed up in two specific clinics each week. Hospital A uses a commercial electronic patient tracking system for both inpatient and outpatient trauma patients. In contrast, hospital B is a smaller secondary care setting and admits 125 hip fractures a year that are cared for on a single inpatient ward. All patients presenting to the Emergency Department with a fracture are referred to a general fracture clinic and also to site specific clinics such as those for hand and wrist. Hospital B does not have a patient tracking system.

Administration

The large numbers of patients the service expected to see required the use of an electronic

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