



RightCare Pathway: Falls and Fragility Fractures

RightCare Pathways provide a national case for change and a set of resources to support Local Health Economies to concentrate their improvement efforts where there is greatest opportunity to address variation and improve population health.

Commissioners responsible for **Falls and Fragility Fractures** for their population should:

- ✓ focus on the three **priorities for optimisation**
 - **Falls prevention**
 - **Detecting and Managing Osteoporosis**
 - **Optimal support after a fragility fracture**
- ✓ work across the system to ensure that schemes to deliver the **higher value interventions** are in place
 - Targeted **case-finding** for osteoporosis, frailty and falls risk
 - **Strength and balance training** for those at low to moderate risk of falls
 - **Multi-factorial intervention** for those at higher risk of falls
 - **Fracture liaison service** for those who have had a fragility fracture,
- ✓ use the Falls Prevention Consensus Statement and Resource Pack, especially the **implementation checklist** – there are links to the relevant sections throughout this resource

The National Challenge

One third of over 65s fall at least once each year and 255,000 result in an emergency admission.

80% of those who had a non-hip fracture weren't offered strength and balance exercises.

Estimated 500,000 fragility fractures per year but less than one third receive bone protecting treatments.

Hip fractures = £1.1 billion in hospital costs and half follow a previous fragility fracture.

RightCare Opportunity

£59m. could be saved on emergency admissions due to falls for those 65 years and over if CCGs achieved the rate of the lowest 5 of their peers

£37m could be saved on hospital admissions for hip and thigh injuries if CCGs achieved the rate of the lowest five of their peers.

System enablers

Cross-cutting: 1. Integrated, multi-agency approach and joint workforce education
2. Focus on environments: high risk care settings and healthy homes
3. Personalised care and support planning, shared decision making

Priorities for Optimisation

Falls prevention

Detecting and managing osteoporosis

Optimal support after a fragility fracture

Higher value interventions

Targeted case-finding for falls risk, frailty and osteoporosis

Strength and balance training for low to moderate falls risk

Multi-factorial intervention for higher falls risk

Fracture Liaison Service plus follow-up at 4 and 12 months

Life course approach to lifestyle risk factors including smoking cessation, reduced use of alcohol & exercise

The evidence

22% of Fire and Rescue Service 'safe and well' home visits resulted in falls assessment

Strength and balance training reduces risk of first, or further falls

Risk assessment and falls prevention (multifactorial) reduces falls by 24%

Effective case-finding and appropriate drug treatment reduces Risks by 50%

Falls and Fragility Fractures

The National Challenge

- We encourage all local health economies to read the Falls and Fragility Fractures [Consensus Statement](#) and [Resource Pack](#) . The supporting resources in this pathway contain links to the relevant sections of both documents. Use the [implementation checklist](#) at the back of the resource pack to make sure you have covered everything.
- As people get older, they are more likely to fall over. The reasons for this are multifactorial – a fall is the result of the interplay of multiple risk factors. These include:
 - having a history of falls
 - muscle weakness
 - poor balance
 - visual impairment
 - polypharmacy and the use of certain medicines
 - environmental hazards and a number of specific conditions.
- Falls are an event. The likelihood and severity of injury resulting from this event is related to bone health. People with low bone mineral density are more likely to experience a fracture following a fall. One of the main reasons why people have low bone mineral density is osteoporosis.
- Over three million people in the UK have osteoporosis and they are at much greater risk of fragility fractures. Hip fractures alone account for 1.8 million hospital bed days and £1.9 billion in hospital costs every year, excluding the high cost of social care.
- Falls and fractures are a policy priority and there is a high degree of expert consensus on the key interventions that local areas should consider if they want to prevent falls and fractures. Recently 18 national organisations published a ‘Falls and fracture consensus statement’ outlining key interventions, approaches to commissioning and commitments to national support.
- Tackling falls and fractures requires a whole system multi –agency approach. There are numerous health and care organisations and professions working with at-risk populations. Activity needs to be coordinated and overseen through effective governance . An important aspect of this is effective joint working between falls and fracture services.
- Preventing falls and fragility fractures and the resulting hospital have been shown to be both clinically and cost effective and will result in substantial cost savings for health and social care services.

Implementation Resources and Practice Examples	<p>Resource Pack – key sections: 2 - Frailty 4 - Case finding and risk assessment</p> <p><u>Fallsafe Care Bundle - North East & North Cumbria</u> Three hospital trusts have introduced an improvement programme to embed the Royal College of Physicians (RCP) guidelines for preventing falls in hospital.</p> <p><u>Targeted Case Finding – Wandsworth</u> An update to Wandsworth Clinical Commissioning Group (CCG) Board on progress in developing and implementing services and initiatives aimed at early identification of patients at risk of developing osteoporosis.</p> <p><u>Toolkit for general practice in supporting older people living with frailty - NHS England</u> A toolkit for GPs, practice nurses and the wider primary care workforce to support the case finding, assessment and case management of older people living with frailty.</p> <p><u>Improving bone health & fracture prevention – Academic Health Science Network - North East & North Cumbria</u> A project to reduce morbidity and mortality associated with fragility fractures</p>

Targeted case finding (cont'd)

Key Criteria	<p>Primary care - consider fracture risk assessments in:</p> <ul style="list-style-type: none">• All women over 65 and men over 70• Adults with fragility fracture, history of falls or systemic glucocorticoid use (NICE QS149)• Other risk factors family history of hip fracture, low BMI, smoking, alcohol more than 14 units per week (CG 146) <p>Fracture Liaison Service:</p> <ul style="list-style-type: none">• Identify all patients over 50 years with a new fragility fracture and a newly reported vertebral fracture (NOS FLS standards)
NICE Resources	<ul style="list-style-type: none">• Falls prevention (CG161)• QS86<ul style="list-style-type: none">1- Identifying people at risk of falls7- Risk assessment if present for med attention• NICE QS149 – Osteoporosis Quality Standard• NICE CG146 – fracture risk assessment• NICE TA160• Case finding with fracture and with before fracture
Guidance	<p>Consensus Statement</p> <ul style="list-style-type: none">3.2 - Case finding3.3 - Risk assessment <p>National Osteoporosis Guideline Group</p>

Strength & Balance Training

<p>Implementation Resources and Practice Examples</p>	<p>Resource Pack – key sections 5 - Strength and balance exercise programmes</p> <p><u>Otago Strength & Balance Training - Queen Elizabeth Hospital Birmingham</u> An exercise programme to improve balance, muscle strength, general fitness and well-being.</p> <p><u>Six month review of active balance classes - Gloucestershire</u></p> <p><u>Strength & Balance Classes - Torbay & South Devon</u> An exercise programme for residents across Torbay and South Devon who have a fear of falling or who feel unsteady.</p>
<p>Key Criteria</p>	<p>Muscle weakness and poor balance are significant risk factors for falls. Strength and balance exercise programmes challenge balance and improve strength through resistance training and exercise in a standing position. They have been shown to reduce the rate of falls.</p>
<p>Guidance</p>	<ul style="list-style-type: none"> • <u>QS86</u> 8 - Strength and balance training • Consensus statement 3.4 – Strength and balance exercise programmes

Multifactorial Intervention

<p>Implementation Resources and Practice Examples</p>	<p>Resource Pack 2 - Frailty 5 - Strength and balance exercise programmes</p> <p><u>A multifactorial approach to falls prevention - Stockport Foundation Trust</u> This article explains why multifactorial intervention is more successful than single intervention at preventing patient falls.</p> <p><u>Falls assessment & education fact sheet</u>– Gloucestershire Care Services</p>
<p>Key Criteria</p>	<p>For people identified via case finding that are potentially at high risk of falls or fractures, evidence based and comprehensive risk assessment should be carried out by a trained healthcare professional, followed by appropriate interventions</p>
<p>Guidance</p>	<ul style="list-style-type: none"> • <u>QS86</u> <ul style="list-style-type: none"> 2 - Multifactorial risk assessment 3 - Multifactorial intervention • NICE <u>TA160</u> and <u>TA161</u> – osteoporosis treatments • <u>FLS Standards</u> • Consensus statement <ul style="list-style-type: none"> 3.3 – Risk assessment • Implementation Resources • Resource pack <ul style="list-style-type: none"> 4 - Case-finding and Risk Assessment

Fracture Liaison Service

Implementation
Resources and
Practice Examples

FLS Clinical Standards (the 'what')

FLS Implementation Toolkit (the 'how' – includes project plan, benefits calculator, business case, service spec, outcome and performance indicators)

FLS Patient Satisfaction Questionnaire

FLS in primary care:

Crawley

The Crawley service is led by a full-time Specialist Nurse Prescriber with clinical support from a GP with a special interest in osteoporosis.

FLS in Secondary Care:

Services offering assessment for all fracture patients over 50 but younger than 76 including DXA scan

Glasgow (external link)

Ipswich (external link)

Oxford – lessons learnt (external link)

North Wales (external link)

FLS in Community Care:

Bridgewater Lancashire

Fracture Liaison Service (continued)

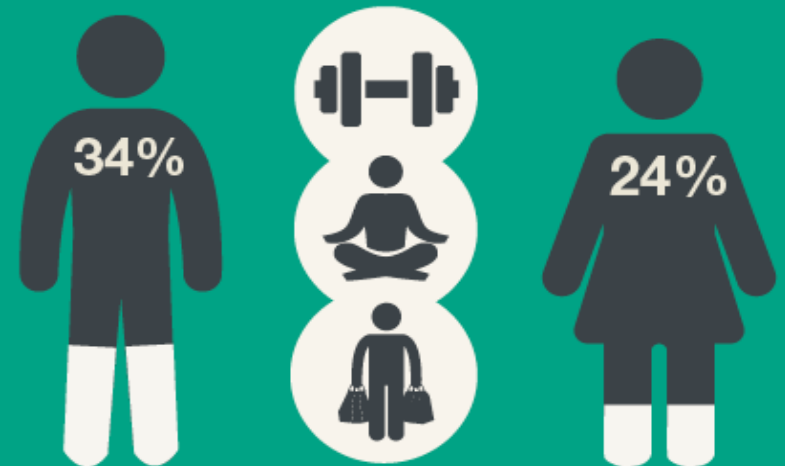
Key Criteria	Fracture liaison services are largely hospital-based services in which a co-ordinator identifies patients aged 50 and over with a first fracture, carries out risk assessments, initiates evidence based interventions for bone health and falls prevention, and monitors adherence and any recurrent events.
Guidance	<ul style="list-style-type: none">• QS86<ul style="list-style-type: none">4 - check for injury after inpatient fall• FLS standards FLS Standards• Falls and Fragility Fracture Audit Programme (FFFAP)• Consensus Statement<ul style="list-style-type: none">3.7 – Fracture liaison services• Resource Pack<ul style="list-style-type: none">8 – Fracture liaison services

How active are we?

1 in 4 women and 1 in 5 men in England are classed as **physically inactive** – doing less than 30 minutes of moderate physical activity per week.



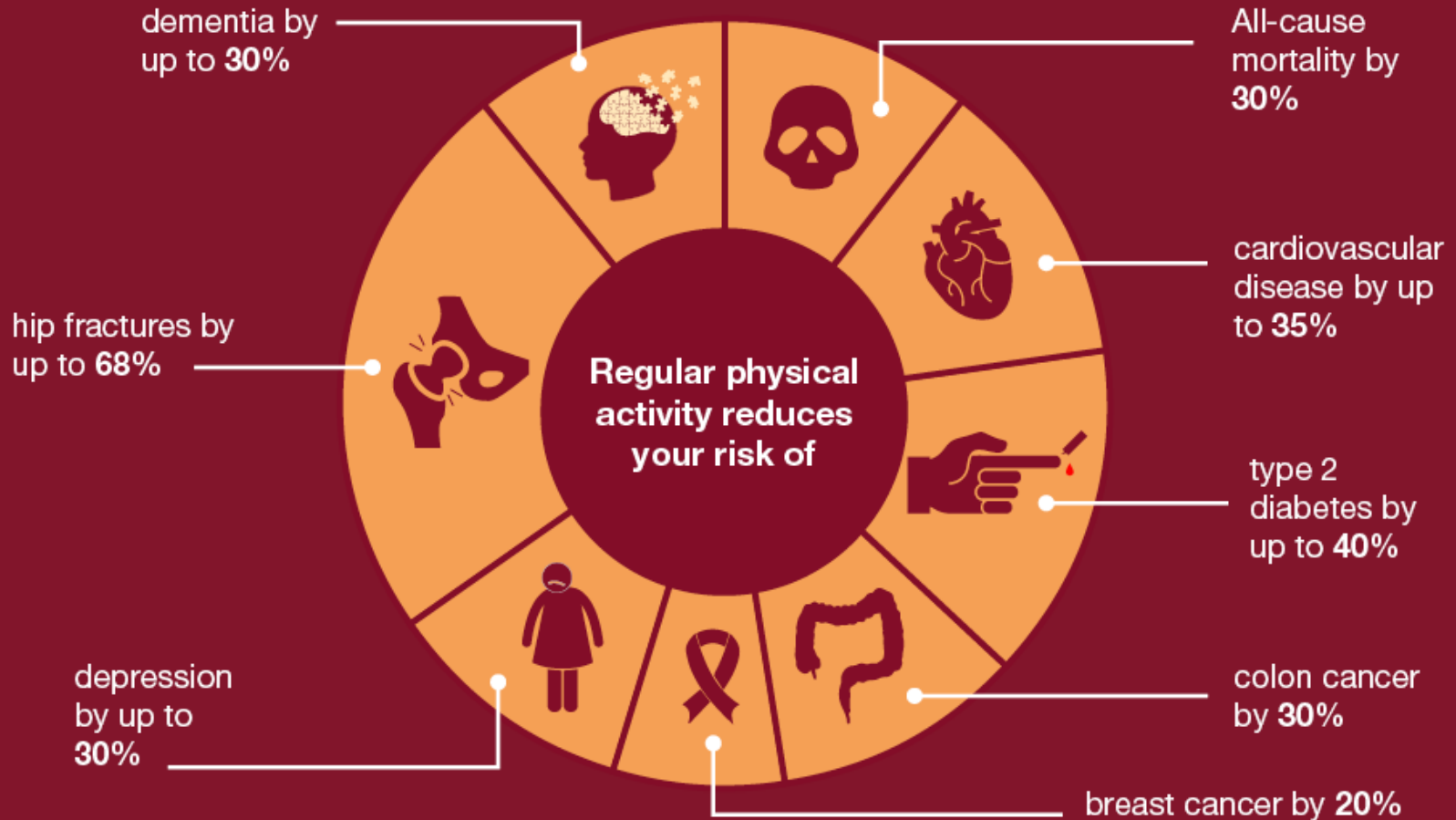
Only 34% of men and 24% of women undertake muscle-strengthening activities at least twice a week.



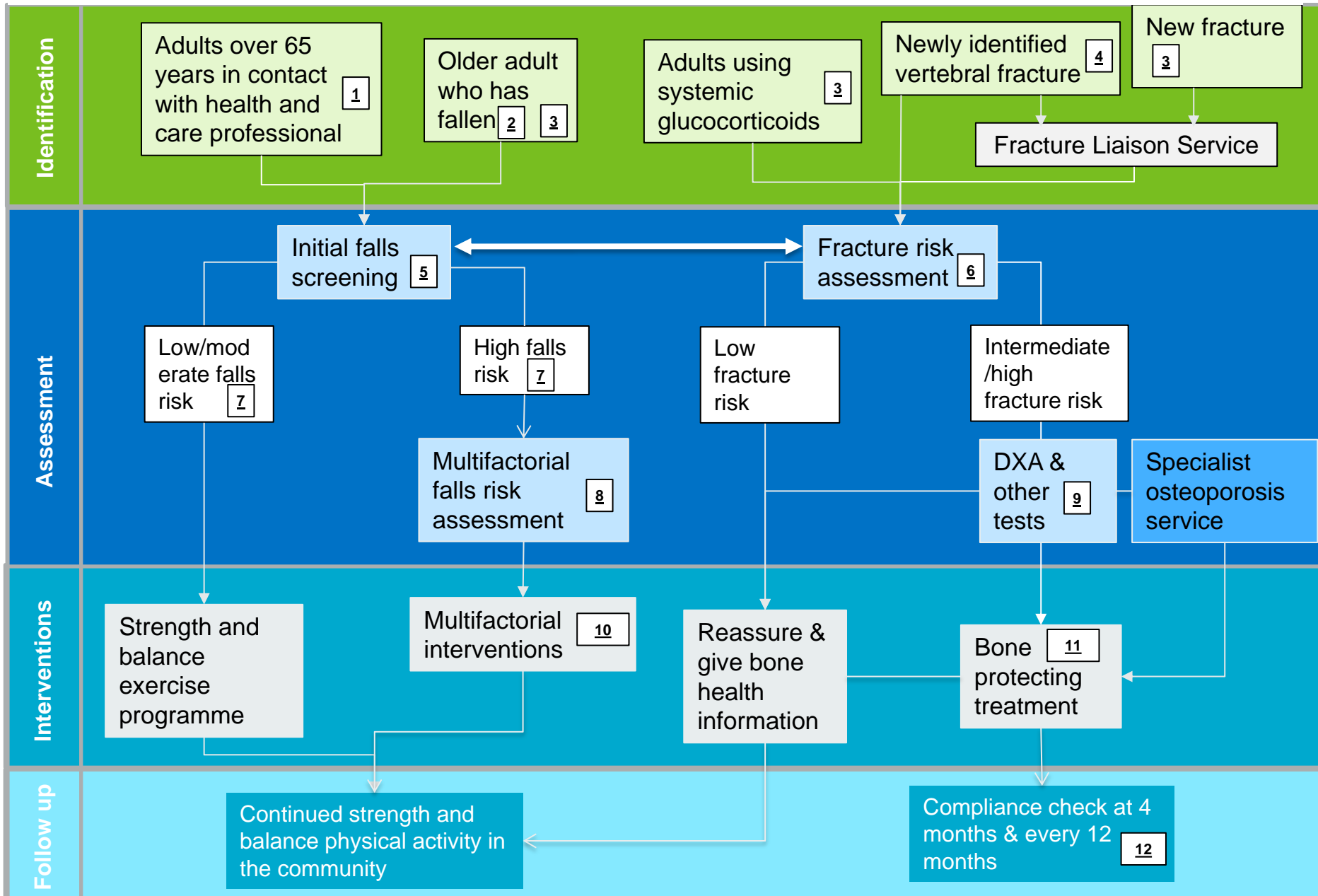
Men are more likely than women to average 6 or more hours of total sedentary (sitting) time on both weekdays and at weekends.



What are the health benefits of physical activity?



Falls & Fracture system prevention diagram showing how the different components of the system are linked



Note: This is not a clinical pathway

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Explanatory notes to pathway slide

1 - NICE QS86 Falls in older people. Older people are asked about falls when they have routine assessments and reviews with health and social care practitioners, and if they present at hospital.

2 - Older adults who have fallen may be identified by ambulance but not transported, or admitted to hospital with injury.

3 - NICE QS149 (Osteoporosis) – highlights the following groups for fracture risk assessment: adults with fractures, adults with history of falls and adults who use systemic glucocorticoids

4 - Vertebral fractures may be identified in imaging being carried out for other purposes. Where this is the case, they should be referred into a Fracture Liaison Service (where in place) and given a fracture risk assessment.

5 - Health and care professionals should screen older people for falls risk. If they judge that the person maybe at high risk of falls then they should refer them for a multifactorial risk assessment. Those at low to moderate falls risk may benefit from strength and balance exercise programmes.

Explanatory notes to pathway slide

6 - NICE CG146 (fracture risk assessment) – recommends use of FRAX or QFracture (SIGN (Scotland and Wales) recommends QFracture). FLS Standards state that everyone coming for fracture risk assessment should be offered initial falls risk assessment.

7 - Reference to low / moderate / high falls risk refers to clinical judgement as to the likelihood of a person falling. The use of tools to classify someone as at low/medium/high risk of falling is not recommended

8 - NICE CG161 – a multifactorial risk assessment aims to identify risk factors and then provide tailored interventions to reduce these risk factors.

9 - NICE CG146

10 - NICE CG161 – interventions may include strength and balance exercise programmes, home hazard assessment and intervention, vision assessment and referral, and medication review with modification/withdrawal of medicines.

11 - TA160 & TA161

12 - FLS standards/FLS-DB

FLS Practice Example - Bridgewater

Case Study: Integrated Falls management & Fracture Liaison Service – Bridgewater Community Healthcare

An integrated multidisciplinary service that provides specialist assessment, diagnosis and treatment for patients who suffer with falls, reduced balance and fractures.

Case Study: An exemplar Community Foundation NHS Trust Integrated Falls Management & Fracture Liaison Service

Bridgewater Community Healthcare

Introduction

The community based exemplary Nurse Consultant lead service is an integrated multidisciplinary service that provides specialist assessment, diagnosis and treatment for patients who suffer with falls, reduced balance and fractures. It provides lifestyle advice, investigations into bone density and underlying conditions and promotes bone health and effective treatment for Osteoporosis. We provide therapeutic interventions to improve strength, balance, mobility and function, which aim to improve confidence, and reduce risk of falls and fractures and promotes independence.

Background

Ageing population & increase cost of falls and fractures (NICE 2013)

Increased pressure on acute services (Banerjee & Conroy 2012)

Transforming Services for Acute Care Closer to Home (DOH 2009)

Evidence base

- Falls Management clinical guidance (NICE 2013)
- College of OT Practice Guidelines (COT 2013)
- Exercise evidence (Sherrington et al 2005)
- NOS – ‘Protecting Fragile Bones’ & International Osteoporosis Foundation - Capture the Fracture
- NICE Clinical Guidance CG146. Osteoporosis: assessing the risk of fragility fractures (2008)
- NICE Technology Appraisal TA161. Secondary prevention of osteoporotic fragility fractures (2008)
- Effective Secondary Prevention of Fragility Fractures: Clinical Standards for Fracture Liaison Services (NOS 2015)

[Continue](#)

Practice Example - Bridgewater

What we do

We assess patients who have had a fall or are at risk of falling and assess patient over 50 years old following a fracture. Through integrated working we provide effective and timely assessment and interventions for our patients. We work in partnership with the local acute NHS trust and other agencies such as local leisure trust, ambulance and fire services, local council, charities and national organisation such as the National Osteoporosis Society and their local patient forum. The established patient pathway ensures that patients who require secondary care are referred appropriately and in a timely manner, therefore providing a cost effective service.

Key Performance indicator – Service outcomes achieved

98% of patients referred are seen under 6weeks

100% of patients assessed against NICE guidance

100% of patients followed up after bisphosphates are commenced. 60% compliance rate at 1 year.

DNA rates FLS- 10% (5% after opt in started)/ Falls-5% (2016/17)

Referral onto secondary care- Falls- 11%, Complex Osteoporosis-19%, other secondary care consultants 1%

Dexa outcomes - 34% of patients assessed following a fracture required a dexa scan, of these; 45% had reduced bone density requiring a follow up scan in 2-3 years; 32% required lifestyle advice only and 22% were diagnosed with Osteoporosis and medication was requested to their GP's.

Education sessions provided

Practice Example - Bridgewater

Feedback

'It seems to be working excellently; I have had lots of positive feedback' (Orthopedic Consultant)

'Made to feel comfortable, explained so I was able to understand and allowed me to ask any questions' (patient)

'Excellent service, friendly, polite knowledgeable workers' (patient).

References

Banerjee, J. and Conroy, S., (2012) Quality Care for Older People with Urgent & Emergency Care needs 'Sliver Book' British Geriatrics Society, University of Leicester. <http://www.bgs.org.uk/index.php/bgscampaigns-715/silverbook?jjj=1446735498960> (accessed 10/9/15)

NICE (2008) National Institute for Clinical Excellence TA 161: Clinical practice guideline for for the secondary prevention of osteoporotic fragility fractures in postmenopausal women <http://www.nice.org.uk/guidance/TA161>

NICE (2013) National Institute for Clinical Excellence Clinical Guidance 161: Clinical practice guideline for the assessment and prevention of falls in older people. <http://www.nice.org.uk/guidance/cg161>

Practice Example - Gloucestershire

Falls Assessment & Education Service - Gloucestershire

Six month review of Gloucestershire active balance classes – July to December 2015.

Falls Assessment & Education Service - Gloucestershire

Six month review of Gloucestershire active balance classes – July to December 2015.

Zoe Spencer and Julia Bradbury - Report completed: April 2017

Executive Summary

The outcome measures have demonstrated consistent overall improvements in function in this 6 month review of the countywide Active Balance Classes (ABC). It indicates that this approach can help to reduce falls, improve balance, confidence and mobility in patients aged 65 and above, who are at risk of falling.

The results however, demonstrate problems with adherence to the programme and with patients continuing to exercise at home or in a community based exercise class.

An action plan will be implemented to make improvements to the programme. Patient education and self-management needs to be enhanced to facilitate patients to be more motivated to attend for up to 12 sessions plus understand the need for continued exercise post ABC. Training will be given to the staff leading the classes by the Falls Clinical Specialists focusing on: - patient centred goals, making the exercises more functional and exercise progression.

FLS Practice Example - Gloucestershire

Background

The aim of the ABC programme is to teach and progress an Otago type home exercise programme with the added benefit of group interaction. The programme is based on best evidence from Laterlife Postural Stability Training (Skelton et al 2005) and also supports NICE QS 86 2015 – Falls in older people. The ABC takes place in a range of venues throughout the county; ARU, community hospital therapy departments and therapy centres and is led by a Therapy Support Worker in the majority of venues. The patient attends the group weekly for 12 weeks and is then reviewed 3 months after finishing the group. Patients are referred into the ABC programme from falls clinics, following assessment by falls clinical specialist or community/ outpatient physiotherapist; GP's and other health care professionals including occupational therapists and district nurses. Patients have to be aged 65 and above who are falling and have a BERG balance score of between 30 – 40 out of 56. There is some variance across county in the ratio of staff to patients but the majority are 1 Therapist: 3 patients or 2:6. There is a physiotherapy ABC record booklet (Y0473) to record outcomes and treatment, which was updated in 2010 and has caused some complications with review of patients and variation in the length of course across the county. The exercise sessions consist of a warm up, dynamic endurance and balance, resistance and cool down, in total lasting approximately 60 – 90 minutes. Patients should be individually assessed and have their exercises progressed as able during the course. To access the ABC exercise programme patients need to have had a physiotherapy assessment and completed outcome measures to include:

- BERG balance score (scored out of 56 with a score over 45 demonstrating good balance)
- Falls Efficacy Scale FES1 (Kempen et al 2008) which is a measure of confidence (scored out of 28 with a lower score demonstrating more confidence)
- Timed Get up and Go (TGUAG) (a mobility measure, normal score if performed in less than 14s)
- Number of Falls (For past 12 months prior to ABC, during the course and 3 month review post ABC)
- Relevant SMART goals agreed with patient and documented

The ABC have been running for many years countywide, but there are issues with non-completion of programmes (12 sessions in total), poor adherence to the home exercise component and patients not being able to attend local community strength and balance exercise classes post ABC prompted this review. The aim of the review was to explore why this is happening and understand how it could be improved.

Continue

Practice Example - Gloucestershire

Evaluation Methodology

3 validated outcome measures (BERG, FES1 and TGUAG) were completed pre, post and 3 months after completion of the programme (explained above).

ABC Venue	Gloucester	Dilke	Stroud	Tewkesbury	Vale	Cirencester	Fairford	Prestbury
Ratio of staff to patients	1.4	1:2	2:6	2.6	1:6	2:8	1:3	2:8
Average age	82-63	80.03	78	86	80.92	78	79.66	82.4
Total no. of pts who completed all 12 sessions	8/13	17/30	5/23	8/13	8/9	13/21	8/16	5/5
Start	38	39.76	34.5	42.2	33	43.77	41.13	42
Berg End	43	49.06	49.8	48.7	41	49.92	48.75	48
3 months	45	47.38	49.8	46.5	47.1	50	48.5	46.2
Start	12.75	14.10	15.89	13.6	14.7	15.15	17.88	12.6
Fes End	10.75	11.58	10	10.1	11	9.23	12.29	10.6
3 months	10.43	11	9.2	10	10	10.15	12.5	9
Start	27.13	20.82	16.5	25.8	13	18.54	23.38	25
TGUAG End	21	16.95	16.4	17.3	13	18.53	22.25	17.2
3 months	22.43	19.13	17.4	15.9	-	21	17.59	14
Start	2.5	2.35	1.9	1.5	5.6	2.62	2.67	2.4
Falls End	0.63	0.12	0.3	0.1	1.4	0.32	0.88	0.4
3 months	0.14	0.53	0.1	0.125	0.375	0.15	0.5	0.4
Patient continuing to exercise at 3 month review	8/8	15/17	5/5	8/8	1/8	10/13	3/8	4/15
Patient attending community exercise class at 3 month review	2/8	5/17	0/5	0/8	0/8	3/13	0/8	2/15

Practice Example - Gloucestershire

The results demonstrate the following:-

- Variance in staff : patient ratio across the county
- Poor completion of all 12 sessions
- Across the board improvements in all outcome measures
- Poor continuance of home exercises and attending a local community strength and balance class

On discussion with ABC staff, some have reported difficulty in the progression of individualised exercises and highlighted a need for more staff training.

Post review discussion/ideas:-

The results of this review were discussed at the countywide Falls Clinical Specialist meetings and it was agreed that some of the budget for the Falls Assessment and Education Service (FAES) could be used to provide training to ABC staff on progression of OTAGO/ PSI exercises. It was therefore arranged for Bex Townley from Laterlife Training to deliver 4 study days on Strength and balance Programmes, exercise principles of progression for increased effectiveness, enjoyment and safety in February and March 2017.

Proposed changes to the ABC

Following the results of this ABC review and also the Bex Townley training the following structured plan was agreed to be taken forward and implemented:-

Continue

Practice Example - Gloucestershire

Criteria and attendance at groups need to reflect changes in practice:

- Staff to patient ratios of 1:4 or 2:8 to ensure that the groups remain safe and efficient.
- Criteria to be clarified so that it is not just dependent on BERG score, so to include the following functional elements :-
 1. Able to sit to stand without assistance of a person
 2. Able to go to the back of the chair without assistance of a person
 3. Able to stand holding onto the back of a chair for 5 minutes
 4. Able to follow instructions
 - Referrers will be asked to ensure that patients have had all appropriate outcome measures completed and a goal/s identified prior to referral – a new referral form will need to be created to help with this.
 - The ABC factsheet will need to be reviewed to ensure that patients are aware of their commitment prior to referral.

There needs to be more emphasis on self-management and teaching home exercises:

- Patients will be informed that the purpose of the group will be for teaching and progressing home exercise
- Home exercises will be taught or reviewed on weeks 1,6 and 12
- 4-5 home exercises can be picked from a list to ensure that they are individualised for the patient
- Patients will be given a pack with identified goals, a record of their outcome measures and 4-5 exercises specific to their goals with a compliance tick sheet. (The pack is patient held and should be scanned on System 1).

Practice Example - Gloucestershire

There needs to be more focus on challenging people to work at their highest level of challenge for balance & strength:

- Weights and resistance bands will be available in the groups for teaching and practice purposes. Patients will be encouraged to self purchase these items.
- A list of self-purchase resource needs to be developed
- ABC staff will need to complete the resistance band competency.
- ABC staff will review backward chaining as a balance and strength exercise as it is important to include getting up from the floor in the ABC programme, which is facilitated by this exercise.
- A workshop led by Falls Clinical Specialists for ABC staff will be set up for Autumn 2017 to review strength and balance exercises used.

Action Plan timescales

- Changes to ABC group content (home exercises and level of challenge) will be the first priority – Aim for implementation end of Summer 2017
- Changes to referral process – Launch to coincide with older peoples day on October 2nd 2017.
- Aim to repeat the six month review July – December 2018 to evaluate the effectiveness of these recommendations and changes to the ABC programme. This review should include more patient feedback which was omitted from this review to ascertain from the patient perspective:
 1. the value of the ABC programme
 2. have the set goals been achieved
 3. what could we do to improve the ABC programme

Practice Example - Gloucestershire

Conclusions

- Recommend a staff to patient ratio of 1:4 or 2:8 In each ABC
- Each programme should try to adhere to 12 session format with 3 month review.
- The criteria needs to focus on functional activity and BERG
- Emphasis must be on exercise and how patients can self-manage/ motivate themselves to continue to exercise
- The exercises included must be more functional and orientated around the patient's SMART goals.
- Backward chaining should be included in the ABC as the review found that this was not being practised routinely.
- This review should be repeated in 2018 with an additional patient feedback questionnaire included.

References:

Physical Activity Guidelines for Older Adults – Department of Health 2011

Skelton, D. A., Dinan, S. M., Campbell, M. G., & Rutherford, O. M. (2005). Tailored group exercise (Falls Management Exercise—FaME) reduces falls in community-dwelling older frequent fallers (an RCT). *Age and Ageing*, 34, 636–639.

NICE Quality Standard 86 March 2015 - Older people living in the community who have a known history of recurrent falls are referred for strength and balance training.

Yardley, L., Beyer, N., Hauer, K., Kempen, G., Poit-Ziegler, C., & Todd, C. (2005). Development and initial validation of the falls efficacy scale-International (FES-I). *Age and Ageing*, 34, 614–619.

Falls Clinical Specialists

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Practice Example – Wandsworth CCG

Falls Prevention & Bone Health progress report – October 2013

An update to Wandsworth Clinical Commissioning Group (CCG) Board on progress in developing and implementing services and initiatives aimed at early identification of patients at risk of developing osteoporosis, better management of patients who have already have osteoporosis and earlier identification and management of patients at risk of falls.

Falls Prevention & Bone Health progress report – October 2013

1. Purpose

The purpose of this report is to update the Wandsworth Clinical Commissioning Group (CCG) Board on progress in developing and implementing services and initiatives aimed at early identification of patients at risk of developing osteoporosis, better management of patients who have already have osteoporosis and earlier identification and management of patients at risk of falls. The focus is on the work carried out in the last year and plans for the next year.

2. Context

Falls and fall-related injuries are a common and serious problem for older people. There are a number of factors which increase the risk of falling. These can be divided into factors which are intrinsic to the individual such as age, being on multiple medications, having visual impairments, having nutritional deficiencies and loss of muscle strength and power as well as extrinsic factors such as poor lighting and slippery or uneven surfaces. A recent analysis of referrals by the Community Services Wandsworth (CSW) Integrated Falls and Bone Health Team to their service shows that for the period under review approximately 80% of people who had fallen fell indoors, and approximately 20% fell outdoors. (Email correspondence from Bernadette Kennedy, Integrated Falls Service Facilitator to Amanda Cranston on 24th April 2013).

Continue

Practice Example – Wandsworth CCG

It is estimated that 20% of older adults will require medical attention for a fall and 5% will experience a serious injury, such as a broken bone (Department of Health 2009). Even when a fall does not result in serious injury it can destroy confidence, leading to increased social isolation, deterioration in mental health and erosion of independence. Underlying the risk factors for fracture following a fall is a common condition known as osteoporosis, which weakens bone strength, predisposing a person to an increased risk of fracture.

On average 50% of people experiencing a non-hip fragility fracture (i.e. wrist, pelvis, vertebral and proximal humerus) will go on to sustain a hip fracture, this population group are a prime target for early intervention (Healthcare Quality Improvement Partnership 2009). Falling is also associated with increased mortality. It is the main cause of accidental death in people aged 85 and over. Hip fractures remain the most serious consequence of a fall and the commonest cause of accident-related death in older people – 20% die within four months and 30% within a year (NHS Institute for Innovation and Improvement 2006).

Please see appendix 1 for detailed public health data on bone health and falls in Wandsworth.

3. Background

The Wandsworth Falls and Bone Health Needs Assessment (2010) clearly identified that there were significant unmet needs for falls prevention services as well as services to address poor bone health. Wandsworth had significantly higher admissions and mortality rates related to falls than seen at national level and only about a quarter of patients with osteoporosis were on appropriate 2

medication. The population in Wandsworth was expected to age over the next 20 years resulting in an increased demand for falls and bone health services.

[Continue](#)

Practice Example – Wandsworth CCG

A strategy was developed with the aim of implementing and delivering high quality services and achieving the best health and quality of life outcomes for patients along an integrated falls prevention, management and bone health pathway. The programme was mapped against Department of Health objectives included in the Guide to Falls and Fractures: effective interventions in health and social care (2009).

4. Falls Prevention, Management and Bone Health Clinical Reference Group (CRG)

The purpose of the CRG is to implement the strategic intentions of the CCG in the commissioning of services for the prevention and treatment of falls and fractures and the maintenance of bone health in older people within Wandsworth. The CRG meets every two months and is chaired by Dr. Charlotte Levitt. The work programme is jointly led by the CCG and Public Health department within the Local Authority and includes representatives from Commissioning, Public Health, Local Authority and local providers to ensure health and social care representation as well as a lay representative to provide the patient voice. See appendix 2 for a list of CRG members.

5. Achievements in 2012/13

Integrated Falls and Bone Health service – Significant non-recurrent investment was used to expand and enhance the Integrated Falls Service. Service developments included improved access to the falls service; development of a community based Fracture Liaison Service to proactively case-find patients who have had fragility fractures in the past or are at risk of osteoporotic fractures and the provision of education, assessment and exercise classes through its B+OOST (Balance and Other Opportunities for Stability Training) and Bone Boost programme.

Practice Example – Wandsworth CCG

Fracture Liaison Service (FLS) – The FLS is based at St George’s NHS Healthcare Trust and targets patients who are admitted to hospital, who attend outpatient clinics and/or A&E due to a low impact fracture. These patients are assessed by a specialist osteoporosis nurse who can investigate bone density, start drug and other treatments to reduce the risk of a future break, liaise directly with falls services as well as monitor and maintain medication adherence.

Non-recurrent investment was identified to increase the number of patients seen by the specialist osteoporosis nurse as well as the number of DEXA scans undertaken. However, it should be noted that the number of patients supported by the FLS did not reach expected levels. This was due to the fact that the post was advertised as a fixed-term position and there was a lack of suitable candidates who applied for this specialist post.

Primary Care Developments –

Case-finding - GP practices were commissioned as part of the Local Commissioning Group Local Enhanced Service (LCG LES) to identify patients over the age of 65 years and on 4 or more medications, who have fallen and/or who have already sustained a fragility fracture to assess their risk of falling.

Medicine Management – Members of the CRG developed local prescribing guidelines for management of patients at risk of osteoporosis and patients for implementation in primary care. An audit was conducted in primary care as a result of a joint working agreement with ProStrakan. 3

Communication and Engagement - The CRG has an engaged patient representative who has contributed to the Communications and Engagement Plan and supported the development of the Guide to Falls Prevention, Management and Bone Health services.

Practice Example – Wandsworth CCG

6. Plans and Progress to Date in 2013/14

Integrated Falls and Bone Health service – The CCG and Local Authority continue to jointly invest in this service to sustain service developments implemented in 2012/13. A part-time pharmacist was employed from September 2013 to sit within the service to monitor medicine use and compliance amongst this cohort of patients.

Fracture Liaison Service (FLS) – The CCG and LA continue to jointly invest in this service. The FLS is currently on track to meet the CCG and LA target of 530 patients being seen by the specialist osteoporosis nurse but it should be noted that service expansion is once again funded through non-recurrent investment which is not a long-term sustainable option.

Primary Care Developments –

Case-finding - The LCG LES has been incorporated into the Planning All Care Together (PACT) LES to continue primary care case-finding.

There are plans to implement an Enhanced Medicine Use Review (MUR) in community pharmacies. Community Pharmacies will provide medicine use and compliance reviews specifically to patients with osteoporosis and identify patients who may require additional support from their GP or would benefit from onward referral into the Integrated Falls and Bone Health Service.

Medicine Management – The local prescribing guidelines were launched at the Quality Outcomes Framework (QOF) Quality and Productivity (QP) Peer Review meeting in September 2013. These guidelines will also support the CCG to meet the local Quality Premium target relating to the secondary prevention of fractured neck of femur.

Communication and Engagement – The CRG plans to work with Lifetimes to deliver a community engagement event. The agenda is yet to be agreed but suggested discussion items include service promotion and medicine management/compliance.

Continue

Practice Example – Wandsworth CCG

Voluntary Sector Developments -

Age UK - The Handyperson Service is commissioned by both the CCG and LA to carry out minor home repairs and adaptations for older people living in Wandsworth. This year, the service has also been commissioned to provide falls risk assessments to these clients as well as to refer appropriate clients into the Integrated Falls and Bone Health Service.

Wandsworth Housing, Adaptations and Repair Forum (WHARF) – The CCG has invested in a part-time WHARF Coordinator who will act as the link between frontline staff members who are in contact with vulnerable residents, as well as health services aimed at preventing falls and promoting seasonal health interventions.

More detail on these areas is available in appendix 3 and the outcomes achieved to date can be found in appendix 4.

7. Significant Proposals

Under the new Health and Social Care Act (2012), the CCG and LA are responsible for the commissioning of falls prevention, management and bone health services. In May 2013, the National Collaboration on Integrated Care and Support published its first paper on “Integrated Care and Support: Our Shared Commitment”. To date, the CRG has already made progress in achieving some of the expectations:

Practice Example – Wandsworth CCG

Engage with local people, patients and people who use services to hear their experiences and work with them to find co-produced solutions

□ CSW Integrated Falls Service ran a focus group with 12 service users to request their input into the development of the new bone health service. Service user feedback was used to develop the Bone Boost programme.

Coordinate care and support so that people and their carers are at the centre and directly involved in planning for the whole person, not just for disease or dependency score

□ In September 2012, members of the CRG attended an Expert Patients Programme Reunion to ascertain what local patients knew about existing services and how to best to promote these services. As a result of this feedback, a guide to local falls prevention, management and bone health services was produced.

Identify opportunities for frontline staff to build relationships with colleagues who provide parallel forms of care and supports to theirs

□ Frontline staff, working both within the NHS and voluntary sector, reported that they are building relationships with colleagues so that they better understand services provided across the borough. This enables staff to deliver coherent and consistent messages to patients in terms of their place in the pathway and continuing care.

Practice Example – Wandsworth CCG

However, there is still progress to be made to fully achieve integrated care and support.

- **Joint allocation of resources** - A local voluntary sector organisation recently approached the CCG to request additional investment to sustain the provision of a falls prevention exercise service for older people within the Wandsworth community centre. As the CCG and the LA have some level of contractual responsibility for the commissioning of these services, there is a current lack of clarity as to which organisation should commission this service.
- **Build relationships with colleagues who provide parallel forms of care and support** – a reorientation of the focus of the falls and bone health programme to include social care as well as health care would provide opportunities for joint work between the CCG and a wide range of Council departments.

In September 2013, a paper was presented to the Health and Wellbeing Board proposing integrated commissioning arrangements across health and social care, which included the proposal for pooled budgets. This paper has been noted but further work is now required to develop formal governance arrangements. .

Practice Example – Wandsworth CCG

8. Recommendation

Wandsworth CCG Board is asked to:

- Note the progress made in the development and implementation of falls prevention, management and bone health services and initiatives in the past 12 months;
- Note the plans for future development in the coming 12 months;
- Note the difficulties in implementing service improvement schemes through the use of non-recurrent investment;
- Recognise the complexity of current commissioning arrangements and to approve the need for pooled budgets and integrated commissioning.

Michelle Heller
Commissioning Redesign Manager
October 2013 .

[Continue](#)

Practice Example – Wandsworth CCG

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