

Report to the Minister of State for Care Services:

**Breaking Through:
Building Better Falls and Fracture Services in England**

February 2012

Foreword

Mr Paul Burstow MP
Minister of State for Care Services
Department of Health
Richmond House
79 Whitehall
SW1A 2NS

February 2012

Dear Minister,

Older people are more likely to use health and social care services compared to any other age group in England; nearly two-thirds of NHS patients receiving consultant-led care are aged 65 and over. Much of this activity is driven by patients who have suffered falls and fractures, an increasingly serious public health issue as our population ages. A significant proportion of these injuries are avoidable and lead to disability, loss of independence and premature death. Falls and fracture patients require multi-agency care and a high degree of integration between NHS and social care services.

In October 2011, you addressed a national falls and fractures summit in London, organised by the National Osteoporosis Society and Age UK. The event was attended by a range of patients, professionals, commissioners and officials from across England.

As you stated in your address to the summit, we know what clinical practice works in preventing falls and fractures. We welcome the opportunity that we have had to partner the Department of Health (DH) in developing the national policy framework for falls and fracture prevention services. The Prevention Package for Older People, published in 2009, offers a clear strategy for tackling the issue. It also sets out the compelling health and economic benefits of commissioning services which avert these costly injuries.

We are, however, concerned that this guidance is only being implemented in a small number settings across England. This is leaving a majority of older people who suffer falls and fractures at an unnecessary and unacceptable risk of sustaining further injuries and broken bones. At 89,000 cases per year, UK hip fracture rates are currently among the highest in the EU.

This document reports on the themes discussed at the summit, which were:

- The current barriers to implementing a comprehensive falls and fracture prevention service across England
- The opportunities we have identified for improving services as a result of the proposed reforms to the NHS, adult social care and public health in England set out in the Health and Social Care Bill

- A suggested set of actions for local and national partners.

As a next step, we propose that a National Falls and Fractures Declaration is drafted and published during 2012. All stakeholders involved in the summit would be invited to sign it, in addition to all NHS, social care and public health commissioning and provider organisations. Partners would be invited to submit an action plan, describing how they would implement the declaration. Progress in achieving the declaration would need to be assessed by a working group. Based on the precedent of the Dementia Action Alliance, resources would need to be committed to co-ordinate and service the operation of such a group.

The overall aim of the declaration would be to slow the rise in the number of hospital admissions for hip fractures in older people over the next five years. This is an outcome measure that we would call upon all partners to sign-up to.

We believe that this provides the best opportunity for ensuring that older people have access to the falls and fracture prevention services they are entitled to. Our goal is an NHS which will empower older people to stay independent and breakfree for longer. As you noted at the event, everyone has a part to play.

Yours sincerely,



Mrs Claire Severgnini
Chief Executive
National Osteoporosis Society



Michelle Mitchell
Charity Director General
Age UK

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Executive summary

Falls and fractures in older people are a **costly and often preventable public health concern**. Government has taken steps to try to mitigate their impact. The National Institute for Health and Clinical Excellence (NICE) has published clinical guidance on the assessment and prevention of falls; the primary and secondary prevention of osteoporotic fractures in post-menopausal women; and the management of patients with hip fracture. NICE is also developing a clinical guideline on the identification of people at risk of osteoporosis or fractures. The Government has published a Prevention Package for Older People: this contains template care pathways and health economic models to help Primary Care Trusts (PCTs) commission falls and fracture prevention services. Osteoporosis has been included in the Quality and Outcomes Framework (QOF). Fracture prevention is included in the 2011/12 NHS Operating Framework and fracture rehabilitation indicators have been incorporated in the 2012/13 NHS Outcomes Framework.

Yet evidence from national audits of falls and bone health show that the fundamental **assessment and treatment of patients recommended by NICE is too frequently not delivered** - in a way which would be intolerable in equally common and costly conditions such as heart disease or stroke. The latest audit, published in May 2011, identifies an **unacceptable variation in the quality of falls and fracture services in England**. It finds a major gap between what organisations report and the actual care provided. The audit shows that patients with **non-hip fragility fractures** are only **half as likely** as hip fracture patients to receive **assessment** and **management** for both falls risk and bone health.

This document summarises the views of a range of stakeholders who took part in the national falls and fractures summit in London on 4 October 2011. Delegates included patients, healthcare professionals, commissioners and officials. All highlighted the causes of this variation and opportunities for improving services. Three key recommendations are as follows:

1. Preventing fractures and hospital admissions is clinically and economically effective and will result in net cost-savings for the NHS and social care; **PCT clusters** and **commissioning consortia** must work with **local authorities** to **commission falls and fracture pathways** and **public health campaigns on bone health and falls prevention in all localities**.
2. Indicators which aim to slow the rise in hospital admissions for fragility fractures must be included in the **NHS, adult social care and public health outcomes frameworks**; commissioners should use **outcome measures** linked to **financial incentives** to drive improvements in the quality of care; patients must be **empowered** to maintain their health, wellbeing and independence.
3. National audits are a very effective tool for improving standards of care. **A real-time national database of non-hip fragility fractures** is needed.

The **next steps should be a National Falls and Fractures Declaration** and a new **commissioning toolkit** for local health and social care economies.

Chapter one: the current state of falls and fracture prevention services in England

Falls and fractures among older people in England are a serious and growing public health issue. In England, between 1998/99 and 2008/09:

- The number of men admitted to hospital for a hip fracture increased by 77%¹
- The overall rise for both men and women was 17%¹
- The number of bed days attributed to hip fractures increased by 32%¹.

Projections show that based on current trends, by 2036, there could be as many as 140,000 hospital admissions for hip fracture a year in the UK - this would be an **increase of 57%** on 2008 admissions^{1 2 3 4}.

The number of bed days attributed to hip fractures will rise sharply; in England, they will increase by 100% between 2008 and 2036¹.

If we do not take steps now to improve the management of patients at risk of falls and fractures, the number of people affected by broken bones will rise steeply in just a few years. The cost of treating and caring for hip fractures in the UK could top **£6billion** by 2036^{1 2 3 4 5 6}.

Much can be done to prevent these fractures, through proper identification, treatment and care for people who have osteoporosis and/or are at risk of

¹ The NHS Information Centre. Hospital Episode Statistics for England. Inpatient statistics, 2007-08. 2010

² Northern Ireland 2007/08 Hospital Inpatient Information. 2010.

³ Data collected on discharges from non obstetric and non psychiatric hospitals in Scotland (SMR1/01). 2010.

⁴ Health Solutions Wales, PEDW Statistics. 2010.

⁵ Long-term inflation assumed to be at 2%, based on Bank of England overview of the Inflation Report November 2010; November 2010, <http://www.bankofengland.co.uk/publications/inflationreport/infrep.htm> [accessed 25 January 2011].

⁶ 2007/08 health and social care cost of a hip fracture assumed to be £25,424, based on: World Health Organisation. Falls prevention in older age. Geneva: WHO Press; 2007, http://www.who.int/ageing/publications/Falls_prevention7March.pdf [accessed 25 January 2011].

falls. Clinical trials have shown that a range of bone protecting treatments, appraised for NHS use by NICE^{7 8 9} can reduce a person's chances of fracture by up to 50%. The first-line bone protecting treatment is generic alendronate; it is cheap and effective and is currently available for £14 per patient per year. A range of evidence-based interventions are also proven to reduce the risk of falls and are recommended by NICE¹⁰.

The best way of reducing the number of fragility fractures suffered by older people is through a comprehensive falls and fracture prevention service, which incorporates an FLS. FLSs are based in fracture units within hospitals, or linked to a number of GP surgeries within primary care.

In 2009, the DH published a suite of documents entitled the 'Prevention Package for Older People'. This provides PCT clusters with the tools and evidence base they need to commission local falls and fracture prevention care pathways. The tools are consistent with current NICE guidance on the management of falls and osteoporosis. A health economic evaluation of these services estimates that comprehensive services serving a PCT population of approximately 320,000 people will:

- Prevent 33 fragility fractures over a five year period
- Save money for commissioners and providers of NHS, adult social care and public health services; over a five-year period, they will cost £234,181 to set up and maintain; in the same period, they will save

⁷ Technology Appraisal 160: Alendronate, etidronate, risedronate, raloxifene and strontium ranelate for the primary prevention of osteoporotic fragility fractures in postmenopausal women. National Institute for Health and Clinical Excellence. 2008 (amended Jan 2010). Available to download from: <http://www.nice.org.uk/TA160>. Accessed on 4 November 2011.

⁸ Technology Appraisal 161: Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women. National Institute for Health and Clinical Excellence. 2008 (amended Jan 2010). Available to download from: <http://www.nice.org.uk/TA161>. Accessed on 4 November 2011.

⁹ Technology Appraisal 204: Osteoporotic fractures – denosumab. National Institute for Health and Clinical Excellence. 2010. Available to download from: <http://www.nice.org.uk/TA204>. Accessed on 4 November 2011.

¹⁰ Clinical Guideline 21: The assessment and prevention of falls in older people. National Institute for Health and Clinical Excellence, 2004. Available to download from: <http://www.nice.org.uk/CG21>. Accessed on 4 November 2011.

£290,708 in treatment and care costs from averted falls and fractures; this represents a net saving of £56,527.

From this, DH have calculated that a comprehensive falls and fracture service across England would bring about an £8.5 million net cost saving over a five year period.

Despite this compelling evidence, only a minority of health and social care economies have a comprehensive care pathway in place. An audit of falls and bone health services in older people in England, Northern Ireland, Wales and the islands was published by the Royal College of Physicians in May 2011¹¹. It was commissioned by the Healthcare Quality Improvement Partnership (HQIP); the audit finds that:

- Only 38% of local health services provide any kind of FLS; not all of these can demonstrate reliable assessment of all fracture patients
- Only 32% of non-hip fracture patients had a multi-factorial falls risk assessment, whereas 68% of hip fracture patients had this assessment
- Only 32% of non-hip fracture and 67% of hip fracture patients have a clinical assessment for osteoporosis or fracture risk
- Bone health treatment remains substandard for the majority of patients; 33% of non-hip fractures and 60% of hip fracture patients received appropriate management for bone health
- Despite 94% of sites stating they use a tool or proforma that includes standardised gait, balance and mobility assessment only 34% of non hip fracture patients and 72% (2389/3318) of hip fracture patients received an assessment.

To mark its 25th anniversary, the National Osteoporosis Society has undertaken a UK-wide survey of over 700 people diagnosed with osteoporosis. It shows that:

¹¹ Falling standards, broken promises: report of the National Audit of Falls and Bone Health in Older People 2010. Royal College of Physicians. Commissioned by the Healthcare Quality Improvement Partnership, 2011. Available to download from: http://www.rcplondon.ac.uk/sites/default/files/national_report.pdf. Accessed on 26 May 2011

- Many are suffering unnecessarily because they are not being identified despite breaking bones or having common risk factors - both of which should raise the alarm for health professionals
- For 70%, osteoporosis was not discussed by their health professional after they broke a bone
- 8% had to raise the subject before it was discussed
- 26% of respondents were only diagnosed after suffering multiple fractures
- 35% had to wait more than a year after breaking a bone before being diagnosed and 22% had to wait more than 5 years.

Data available about falls and fractures

In addition to the National Hip Fracture Database (NHFD) and the national falls and bone health audit in older people, other sources of information about incidences of falls and fractures available to commissioners are as follows:

- Hospital Episode Statistics (HES)
- General Practice Research Database (GPRD)
- The Association of Public Health Observatories (APHO) Public Health Profiles includes age-standardised hospital admissions for hip fracture in patients over the age of 65; this is profiled and mapped for each English district and county-level local authority¹².

¹² Health Profiles Interactive. The Association of Public Health Observatories (APHO) Public Health Profiles. 2011. Available to download from: http://www.apho.org.uk/default.aspx?QN=HP_INTERACTIVE2011. Accessed on 4 November 2011.

The current policy framework

There are a number of public policy documents already in place which advocate comprehensive falls and fracture prevention services. In chronological order, they are as follows:

- The **National Service Framework for Older People** standard on falls¹³
- **Active for life: Promoting physical activity with older people guidelines**¹⁴
- **NICE Clinical Guideline 21: falls**¹⁰; NICE announced in August 2011 that CG21 would be updated to include an extension of the scope to cover inpatient settings and service delivery
- The **Musculoskeletal Services Framework**¹⁵
- **Urgent Care Pathways for Older People with Complex Needs: Best Practice Guidance**¹⁶
- **NICE Technology Appraisals (TA) 160**⁷ and **TA161**⁸ on the primary and secondary prevention of osteoporotic fractures in post-menopausal women

¹³ The National Service Framework for Older People. DH. 2001. Available to download from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066. Accessed on 4 November 2011.

¹⁴ Active for life: Promoting physical activity with older people guideline. Health Development Agency. 2003. Available to download from: http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/hda_publications.jsp?o=159. Accessed on 22 November 2011.

¹⁵ The Musculoskeletal Services Framework. DH. 2006. Available to download from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4138413. Accessed on 4 November 2011.

¹⁶ Urgent Care Pathways for Older People with Complex Needs: Best Practice Guidance. DH. 2007. Available to download from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_080136.pdf.

- The **Prevention Package for Older People** (2009)¹⁷; this sets out a systematic approach to falls and fractures prevention (see **Figure 1** on page 14) and contains the following documents, which are targeted at commissioners of NHS and adult social care services:
 - Falls and fractures: effective interventions in health and social care
 - Falls and fractures: exercise training to prevent falls
 - Falls and fractures: developing a local joint strategic needs assessment
 - Fracture prevention services: an economic evaluation
 - Hip fracture including the secondary prevention of further fractures related to falls and bone fragility
 - Falls and fragility fracture secondary prevention pathway
- **NICE Technology Appraisal 204**⁹ on denosumab for preventing bone fractures in some postmenopausal women with osteoporosis
- The **Best Practice Tariff for Hip Fracture**¹⁸; this is underpinned by the standards of care set out by the British Orthopaedic Association and British Geriatrics Society's 'Blue Book'¹⁹
- The **2011/12 NHS Operating Framework**²⁰ states, on page 46, that PCTs are asked to take steps to reduce incidence of fractures; it notes

¹⁷ The prevention package for older people. DH. 2009. Available to download from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh_103146. Accessed on 4 November 2011.

¹⁸ Best Practice Tariff for Hip Fracture Care user guide - 2011 update. National Hip Fracture Database. Available to download from: http://www.nhfd.co.uk/003/hipfractureR.nsf/BPT_User_Guide.pdf. Accessed on 4 November 2011.

¹⁹ The care of patients with fragility fracture. The British Orthopaedic Association and the British Geriatric Society. 2007. Available to download from: [http://www.nhfd.co.uk/003/hipfractureR.nsf/6ec433ed9efaa78e802572e3003a3517/74ae78030e6ffa3a8025779f0041fbcc/\\$FILE/Blue%20Book.pdf](http://www.nhfd.co.uk/003/hipfractureR.nsf/6ec433ed9efaa78e802572e3003a3517/74ae78030e6ffa3a8025779f0041fbcc/$FILE/Blue%20Book.pdf). Accessed on 4 November 2011.

that the best way to prevent this transformative injury is to “recognise precursor or ‘herald’ fractures and give patients a bone health assessment and treatment when they first show clear signs of being at risk”

- **The NHS Outcomes Framework 2011/12²¹** includes an indicator measure of the proportion of fragility fracture patients recovering to their previous levels of mobility/walking ability at (i) 30 days and (ii) 120 days
 - The **2010 Comprehensive Spending Review²²** states that “the NHS will set aside funding growing to £1 billion by 2014-15 within their settlement to fund new ways of providing services, including reablement services provided by the NHS. This will help to break down the long-standing barriers between health and social care, leading to benefits across the health and social care system”
 - The draft **Public Health Outcomes Framework²³** includes an indicator measure of acute admissions as a result of falls or fall injuries for over 65s
 - **The Adult Social Care Outcomes Framework 2011/12²⁴**, whilst not including indicators specific to falls or fractures, does state “(although an indicator on) ‘the proportion of people suffering fragility fractures who recover their previous level of mobility/walking after 120 days’ has
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²⁰ The Operating Framework for the NHS in England 2011/12. DH. 2010. Available to download from:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122738. Accessed on 4 November 2011.

²¹ NHS Outcomes Framework. DH. 2010. Available to download from:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944. Accessed on 4 November 2011.

²² Spending Review 2010. HM Treasury. Available to download from: http://cdn.hm-treasury.gov.uk/sr2010_completereport.pdf

²³ Healthy Lives, Healthy People: Transparency in Outcomes Proposals for a Public Health Outcomes Framework - a consultation document. 2010. DH. Available to download from:

http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_123113.pdf. Accessed on 4 November 2011.

²⁴ Adult Social Care Outcomes Framework. DH. 2011. Available to download from:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125686.pdf.

not been included in the 2011/12 ASCOF because further work is needed on data development and analysis of the impact of social care, we believe this may prove an effective inclusion in the future, and will keep work under review”

- The **Commissioning for Quality and Innovation (CQUIN)**²⁵ payment framework enables commissioners to reward excellence by linking a proportion of provider income to local quality improvement goals; ‘Fragility fractures Fracture Prevention Service’ is included as an exemplar CQUIN goal
- **NICE Clinical Guideline Wave 81 Number 51: Hip Fracture**²⁶
- **Draft Hip Fracture Quality Standard**²⁷.
- **The Quality and Outcomes Framework (QOF) 2012/13:** from April 2012 osteoporosis will be included in the UK-wide GP contract as part of the QOF; GP practices will receive funding for:
 - Producing a register of patients (a) aged 50-74 years with a record of a fragility fracture after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan; or (b) aged 75 years and over with a record of a fragility fracture after 1 April 2012.
 - Ensuring that patients on the register who are aged between 50 and 74 years, with a fragility fracture, in whom osteoporosis is confirmed on DXA scan, are treated with an appropriate bone-sparing agent.

²⁵ Commissioning for Quality and Innovation (CQUIN) payment framework. NHS Institute for Improvement and Innovation. 2011. Available to download from: <http://www.institute.nhs.uk/images/documents/wcc/PCT%20portal/CQUIN%20schemes2/2010.11.25%20Exemplars%20FINAL.doc>. Accessed on 4 November 2011.

²⁶ Clinical Guideline Wave 18 Number 51 - Hip Fracture. National Institute of Health and Clinical Excellence. 2011. Available to download from: <http://guidance.nice.org.uk/CG/Wave18/51>. Accessed on 4 November 2011.

²⁷ Hip Fracture. National Institute for Health and Clinical Excellence. 2011. Available to download from: <http://www.nice.org.uk/guidance/qualitystandards/indevelopment/HipFracture.jsp>. Accessed on 4 November 2011.

- Ensuring that patients aged 75 years and over with a fragility fracture are treated with an appropriate bone-sparing agent.

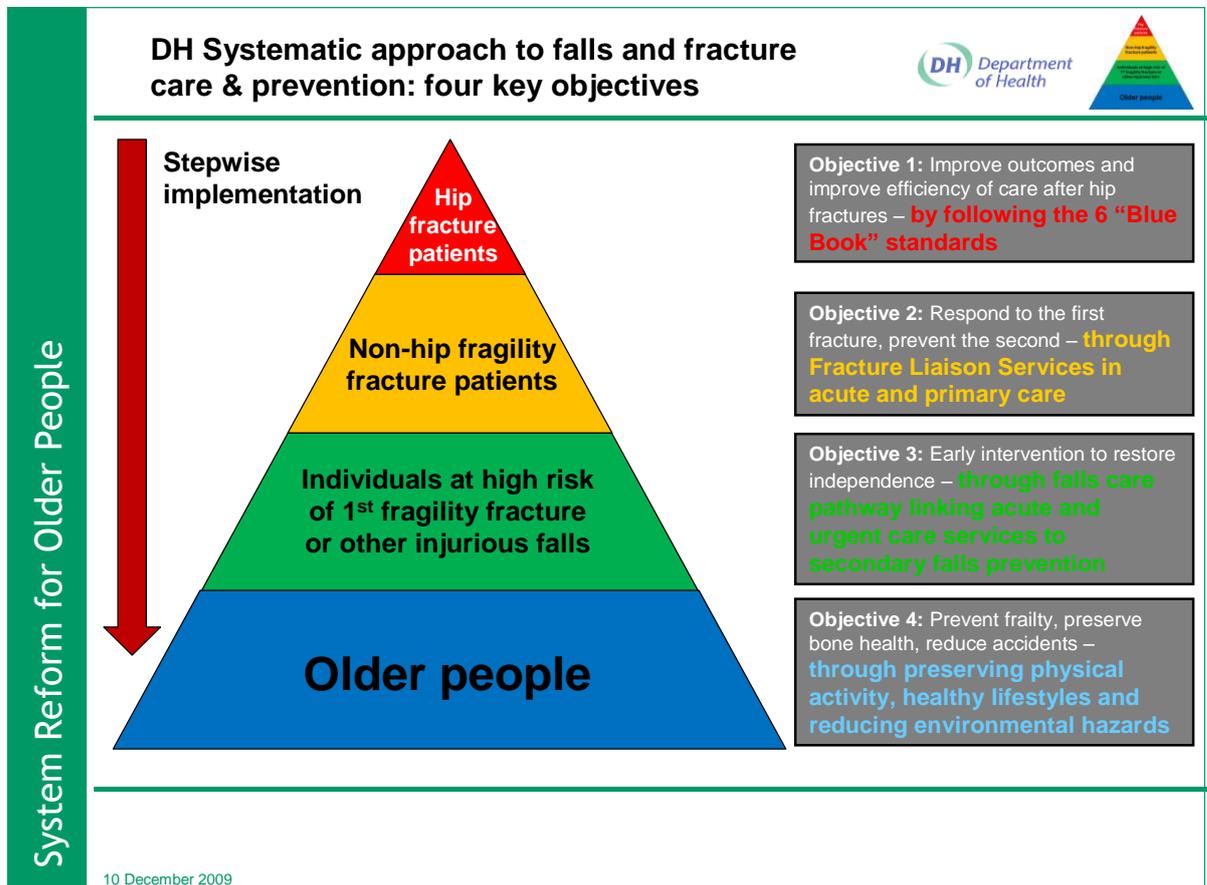


Figure 1: The four key objectives of the DH’s systematic approach to falls and fracture care and prevention.

Chapter two: the barriers to a comprehensive falls and fracture service

If a patient is at risk of falls and broken bones, they can be identified by a variety of different professionals in a number of settings. These include:

- At home by Emergency Care Practitioners (ECPs)
- In Accident & Emergency departments
- Orthopaedics
- Care of older people
- Rheumatology
- By Fracture and/or Falls Liaison Nurses (or equivalent positions)
- General Practice
- Intermediate care
- Community care
- Residential and nursing care homes
- Out of hours General Practice services.

It is arguably easier for professionals to be alerted to an individual's future risk of suffering a fall or fracture once they have been admitted to hospital. This could be one of the explanations for the higher rate of identification, assessment and treatment for secondary falls and fracture prevention among hip fracture patients compared to patients who suffer other types of fracture¹¹.

Falls-related injuries are recorded in secondary care. However, variations in outcomes arise from how this information is then used. Health and social care economies which provide best-practice care record both the fall and the resulting injury, ensuring that the patient is referred for assessment and treatment where necessary. In a number of settings, a dedicated professional (typically a Fracture and/or Falls Liaison Nurse) will have access to information about incidences of falls and fractures (or will be physically present in fracture clinics) to enable them to identify at-risk patients. The patients are then referred to a secondary care clinician or a General Practitioner for a risk assessment.

Unfortunately this does not occur for the majority of cases in England, for a variety of reasons:

- Only the injury and not the fall is **coded** - this means that other professionals are not able to identify patients as being at risk of further falls and related injuries
- In some cases, **ECPs** do not record falls which are not conveyed to hospital
- Only a **minority of local health and social care economies (35% in England) commission and employ a Fracture Liaison Nurse or an equivalent post**; all best-practice examples of Fracture Liaison Services include such individuals, either in secondary or primary care; where a Fracture Liaison Nurse is not in post, information about a fall or fracture is passed from the setting in which it is recorded to the GP practice, where it is often not acted upon; secondary care professionals often will assume that primary care professionals will initiate follow-up assessments, whilst GPs may not have the awareness or expertise to identify a fall or fracture as a trigger for further investigation
- There is a **lack of awareness** among patients, carers and professionals that a fall or fracture in an older person requires further assessment and possible treatment; too often, falling and breaking a bone is regarded as an inevitable part of getting old.

Inadequate recording of falls and related injuries also impacts upon the commissioning process: where officials are unable to access reliable data about falls in older people within an area, it is impossible to prove that falls and fractures are a local public health problem. Such a scenario makes it unlikely that falls and fractures will be included in a local Health and Wellbeing Strategy, or that a care pathway will be seen as a commissioning priority.

Summit delegates have identified a number of other barriers which prevent recommended services from being commissioned and provided:

- PCT clusters are generally **unaware** of the tools available to them in the Prevention Package for Older People
- Even where commissioners are aware of the tools, they are **unwilling to make short-term investments** in falls and fracture care pathways, *despite* the health economic evidence
- **There is no incentive payment for PCT clusters** to commission a falls and fracture prevention service; there is no immediate financial reward or fear of being held to account by the Care Quality Commission if NICE guidance on the management of falls and fractures in older people is not implemented

- There is a **lack of nationally-recognised outcomes measures** for commissioners to achieve in preventing falls and broken bones (for example, the inclusion of an indicator on hospital admissions for falls and fractures in the NHS, adult social care and public health outcomes frameworks)
- There is a **lack of communication** between professionals who would deliver a local falls and fractures care pathway; this leads to a lack of knowledge of the range of services available for patients to be referred on to
- There is a **lack of involvement from falls and/or fracture patients, carers and the organisations that represent them in local commissioning processes**
- There is a **lack of knowledge** of osteoporosis, falls and fractures among some professionals; in social care settings, some professionals are failing to help patients to adhere and comply with bone-protecting treatments (for example, by administering medication at the wrong time of day and/or with food and drink); some professionals are also unclear who to present evidence of rising trends in falls and fractures to
- There is a **dearth of 'clinical champions'** for falls and fracture services in local areas
- There is a **lack of reinvestment of Best Practice Tariff funds** by NHS Trusts in falls and fracture prevention services; some trusts view secondary prevention of falls and fractures as a primary care responsibility, due to a perception that this is where financial savings will be made; in fact, provider organisations will achieve cost-savings if improvements to falls and fracture services are put in place
- Too few NHS Trusts or care homes have protocols in place to prevent, identify or act upon **falls among inpatients** or residents
- There are **too few real-life examples of best-practice** available for commissioners and professionals to use as precedents or to compare their own services against
- Best-practice falls and fracture care pathways are **too complex**
- There is an **under-emphasis on the secondary prevention of falls and fractures** in comparison to rehabilitation and reablement
- Some **patients are unwilling to be identified as frequent fallers** for fear of being stigmatised
- Some patients are **unwilling or unable to adhere and/or comply with prescribed treatments**

- It **takes too long to undertake a fracture risk assessment** in Accident and Emergency or during a GP appointment.
- Despite evidence that individuals of all ages can take steps to reduce their risk of falls and fractures in later life, PCT clusters have not been doing enough to promote such messages through **local public health campaigns**; no financial incentives have been offered to PCTs to tackle falls and fractures as a public health issue.

Chapter three: does the new NHS, adult social care and public health architecture in England provide opportunities to improve the provision of falls and fracture prevention services?

Summit delegates have identified a number of potential opportunities in the reforms proposed in the Health and Social Care Bill:

- **Clinical commissioning groups** in the NHS could provide greater opportunities for health professionals from all areas of a falls and fracture prevention pathway to influence the design of services
- **Clinical senates** should also be a means of increasing professional influence upon the commissioning process; it is proposed that these bodies bring clinical leaders together across broad areas of the country to provide a vehicle for cross speciality collaboration; given the cross-cutting nature of falls and fracture care pathways, this could be a positive development
- **Clinical networks** could provide a forum for professional experts in the field of falls and fractures to share best practice and influence commissioning
- The proposed **Health and Wellbeing Boards** offer an excellent opportunity for holistic approaches to health, social care and public health to be taken across local areas; they could engender a multi-agency approach, involving bodies such as housing associations; delegates were keen that boards oversee the design and delivery of falls and fracture care pathways, ensuring that each element of the service is integrated and patient-focussed; they could also oversee the delivery of campaigns by Local Authorities through the proposed local public health service designed to promote healthy lifestyles
- The proposed **HealthWatch** organisations could also provide a stronger voice for patients and carers in the commissioning process
- The focus on achieving **health and wellbeing outcomes** was welcomed; given that the DH document 'Fracture prevention services: an economic evaluation'¹⁷ proves that comprehensive services reduce incidences of fragility fractures over a five-year period, delegates were keen that reducing fractures in older people should become a desired outcome measure at both national and local levels
- In light of the success of the Best Practice Tariff for Hip Fracture, delegates were keen that **financial incentives** should play a greater role in the commissioning and provision of services; the introduction of a Quality Premium payment for commissioners in return for improving health and wellbeing outcomes among patients could reduce falls and fracture rates; a Health Premium payment for Health and Wellbeing

Boards which produce similar public health outcomes for local populations would also be supported

- **Monitor's** role in scrutinising the NHS's economic performance could also offer an opportunity; commissioning a comprehensive falls and fracture care pathway is proven to achieve net-cost savings; as a result, Monitor should hold to account those consortia and provider organisations which fail to commission or deliver such services on the grounds that they are not achieving value for money for the NHS
- Plans to improve **information** and **choice** in the NHS open up the prospect of patients and carers being able to choose which geographical area and/or clinical team they receive their treatment from; it could provide opportunities for more creative means of getting information to patients; it could also lead to a greater number of patients having access to comprehensive falls and fracture prevention services if they are willing and able to travel away from their local area; however, it could also lead to greater health inequalities, whereby patients and carers who are unable to travel and/or access information about service quality are left at a disadvantage
- There could be opportunities for **third sector** organisations to provide elements of local falls and fracture care pathways.

Although not part of the Health and Social Care Bill, the **QIPP** challenge provides a significant opportunity to promote comprehensive falls and fracture care pathways. Given that falls and fracture services are proven to reduce hospital admissions for broken bones, they can help to improve the quality and efficiency in the NHS.

Threats

Delegates also highlighted a number of threats posed by the reforms:

- The potential increase in diversity of organisations providing different elements of falls and fracture care pathways could **fragment** services and make them **less integrated**
- Professionals working in secondary, intermediate, community and social care must be involved in the commissioning process to bring about integrated services; however, **conflicts of interest** could arise if invitations to input into the pathway-design process are not extended to all potential provider organisations
- Provider organisations may be **reticent to share best practice** with competitors
- During the coming years, the NHS, social care and public health services could become **too pre-occupied with organisational change** rather than improving services

- Services which delivery faster health economic outcomes may be prioritised over falls and fracture prevention services.

Chapter four: what steps are needed to put a comprehensive falls and fracture prevention service in place and who needs to take them?

During the falls and fractures summit, delegates made a number of suggestions for overcoming the barriers which impede the commissioning and delivery of comprehensive falls and fracture services. The common themes which emerged from the event are as follows:

- GP practices must ensure that all older fracture patients (particularly those who suffer non-hip fractures) on their registers are identified, assessed for osteoporosis and treated with bone-protecting medication where necessary - this will enable them to achieve incentive payments as part of the **2012/13 QOF**; GPs must use the new commissioning responsibilities proposed for them to press for comprehensive falls and fracture care pathways to be designed and implemented in their local areas
- PCT clusters (and the commissioning consortia that are proposed to replace them) must work with local authorities to **implement existing guidance and commission comprehensive falls and fracture prevention care pathways**; they hold the vast majority of the NHS budget and are arguably the most influential stakeholders in this process; pathways must take **non-hip fractures** into account on the basis that they are often a precursor to a potentially life-threatening and costly hip fracture later in life; pathways must also include **rehabilitation and reablement** services for fragility fracture patients; commissioning consortia will be required to deliver improved rehabilitation and reablement outcomes for such patients as a result of the 2011/12 NHS Outcomes Framework.
- Local Authorities must **commission public health campaigns** to promote good bone health and healthy lifestyles to reduce falls risk in later life
- Following on from the Prevention Package for Older People, **fresh guidance** on how to **commission (a) falls and fracture care pathways** and (b) **public health campaigns** on bone health and falls risk must be produced for the proposed new commissioning consortia and Local Authorities; a national **template care pathway for the primary prevention of falls and fractures** should be developed
- **The coding of falls and fractures within the NHS must be improved** - a patient's fall must be coded *in addition* to the resulting injury they sustain; without this step, it is very difficult to ensure that a follow-up falls-risk assessment will be carried out
- There must be a **better flow of information** about patients who fall and/or fracture between the NHS, social care, public health and other

services; **all must assume responsibility** to ensure that patients are adequately managed and receive assessment and treatment to reduce their risk of further injuries

- **Ambulance Trusts and bodies organising out of hours General Practitioner services** must ensure that all ambulance staff and GPs record and pass on information about older people who fall, especially those who are **not conveyed to hospital**
- NHS Trusts and care home providers must also be put in place to prevent, identify and act upon **falls** and falls-related injuries which occur among **hospital inpatients** and **care home residents**
- **Auditing** of admissions for falls and broken bones must be improved; a **real-time national audit** of the prevention and care of falls and fracture should be introduced; this should lead to **greater transparency and better local information** about incidences of falls and fractures, the quality of local services and outcomes achieved for patients
- Local commissioning organisations should **publish details of falls and fracture care pathways** in full
- Local commissioners should invite all potential provider organisations to participate in the process of designing falls and fracture care pathways
- Initiatives designed to improve efficiency and bring about better clinical outcomes for patients, such as **QIPP** must help to emphasise the role that falls and fracture prevention services can play in achieving these aims
- **Fracture Liaison Nurses** or equivalent personnel must be employed either in primary and secondary care; they must be based at or link into all hospitals which receive fracture patients; time and resources must be given to Fracture Liaison Nurses to enable them to:
 - identify at-risk patients
 - investigate why patients have fallen and/or broken a bone
 - initiate treatment where appropriate
 - provide information about lifestyle measures; how to cope with falls, fractures and treatment to prevent them; and the organisations which can provide them with caring support

- Indicators which measure hospital admissions resulting from falls and/or fractures must be included in the NHS, adult social care and public health **outcomes frameworks**
- **Financial incentives** must be offered to commissioning consortia and Local Authorities that improve outcomes for older people with or at risk of falls and fractures, through NHS, adult social care and public health services
- Some delegates suggested that the DH should provide hypothecated (or **ring-fenced**) **funding** to commissioners to ensure that falls and fracture services are set up
- **Co-ordination must be improved** between the NHS, social care, housing, the public health service and the voluntary sector
- Examples of **best-practice** in the commissioning and provision of services must be widely disseminated; patients, carers, professionals, commissioners and the public should be given more guidance on how to access it
- **GPs must be better educated** about falls and fracture risk, both in their initial training and continuing professional development (CPD); GPs must also be informed about the medical conditions which contribute to falls and fracture risk; they should know how and when to conduct the FRAX fracture risk assessment
- There must be greater **clinical leadership** in the commissioning and provision of falls and fracture prevention services
- **Care homes** must help health professionals to implement guidance produced by NICE and the DH on **calcium** and **vitamin D** supplementation; this should take the form of ensuring that residents - particularly those who are cognitively impaired - are given supplements in the right way, at the right time
- A set of **national standards** on the prevention and management of falls and fractures should be adopted for **care homes**; this could be

based on Social Care Social Work Improvement Scotland's (SCSWIS) recent 'Managing falls and fractures in care homes for older people – a good practice self assessment resource'²⁸

- This may necessitate **better training for care home managers and staff**
- Improving patient outcomes on falls and fracture prevention must be included in local authority **care home contracts**
- **Patients** who are able to should **take prescribed treatments, attend strength and balance classes** and **follow lifestyle advice** as directed by the health professionals caring for them; patients must be **empowered** to maintain their health, wellbeing and independence.
- The **Care Quality Commission (CQC)** must hold to account commissioners and providers of care that are not implementing national guidance
- Cross-cutting, multi-agency initiatives must be put in place to **promote healthy lifestyles** among older people, aimed at preventing frailty and promoting good bone health
- Public awareness of falls and fracture risk must be improved through a national **public health campaign** which seek to reduce falls risk and improve bone health; the campaign should raise awareness of the steps that must be taken if an older person falls and/or fractures; it must **explode the myth** that falls and broken bones are an inevitable consequence of getting old and cannot be prevented; as the **F.A.S.T. campaign**²⁹ makes clear to patients, carers and health professionals the immediate steps that should be taken following a stroke, so a falls and fractures campaign should emphasise (albeit the relatively less

²⁸ Social Care Social Work Improvement Scotland (SCSWIS). Managing falls and fractures in care homes for older people – a good practice self assessment resource. 2011. Available to download from:

http://www.scswis.com/index.php?option=com_content&task=view&id=7906&Itemid=725.

Accessed on 11 November 2011.

²⁹ Stroke - Act F.A.S.T. DH, 2011. Available to download from:

<http://www.nhs.uk/actfast/Pages/stroke.aspx>. Accessed on 11 November 2011.

urgent) importance of assessment and treatment after a patient's acute condition following a fall or broken bone have been managed

- Ultimately, falls and fractures in older people must be **de-normalised**
- Greater attention must be given to the needs of **Black and Minority Ethnic** (BME) patients who are at risk of falls and fractures
- **Repeat prescriptions** should include printed questions which ask patients if they have suffered a recent fall
- Health and social care professionals should set up **local falls and fracture networks** to share best-practice and influence commissioning decisions
- **Professionally-led standards on Fracture Liaison Services** should be developed.

Recommendations

Taking the above suggestions into account, a recommended action list for the range of organisations with a stake in falls and fracture services is as follows:

All partners

- Following on from the Prevention Package for Older People, all must design and publish **fresh guidance** on how to **commission** (a) **falls and fracture care pathways** and (b) **public health campaigns** on bone health and falls prevention; the guidance should be designed specifically for the proposed new commissioning consortia, Health and Wellbeing Boards and Local Authorities; it must include a national **template care pathway for the primary prevention of falls and fractures**; it should provide local health and social care economies with the tools they need to implement all four levels of the DH's systematic approach to falls and fractures care & prevention; it must be published this by **October 2012**.
- All should design and implement a **national campaign** for commissioners, professionals and the general public which:
 - discredits the myth that it is normal for older people to fall and break bones
 - tells patients and carers what they should do in the event of a fall or fragility fracture
 - tells patients and carers about risk factors for falls and fractures

- tells patients and carers about the steps they can take to reduce their risk of falls and fractures.
- All must **take responsibility and take the initiative for every patient** - partners should not assume that patients who have suffered or are at risk of falls and/or fractures will be identified by another part of the NHS or social care system; they must be referred to the appropriate part of the care pathway or advised to see their GP.
- All should ensure that the work they do is **planned and informed by the views of people with or at risk of falls and fractures and their carers**.
- All must be an **ambassador** for a National Falls and Fractures Declaration.
- All should **report publicly** on progress against the delivery of a National Falls and Fractures Declaration.
- All must work in **partnership** with other organisations to share knowledge about best practice in preventing falls and fractures in older people.

Patients who have suffered or are at risk of falls and broken bones (including their carers)

- Should feel **empowered** with knowledge on how to maintain their health, wellbeing and independence.
- Where they are yet to receive one, patients must **have the information so that they can ask for a falls and fracture risk assessment** from the health professionals who are caring for them.
- Patients should **follow courses of prescribed treatments** and/or supplements that they have agreed to take.
- Where they are unhappy with their treatment or are unable to take it, patients should feel confident telling the health professionals who are caring for them as soon as possible; patients should **give feedback** - both positive and negative - about treatment they have received.
- Patients should ask their GPs to **review their medication** on a regular basis.
- Patients should recognise that they can make a significant contribution to **their own health and wellbeing**; in terms of falls and bone health, some of the steps they should consider (if they are able) include regular exercise; a balanced diet; moderate alcohol consumption; tobacco avoidance; safe sunlight exposure during the summer months;

regular eye tests; and making their homes as safe as possible by minimizing hazards which could cause slips and trips.

Organisations which represent older people with or at risk of falls and broken bones

- Should raise awareness of the risk of falls and broken bones and the interventions that can reduce the risk among older people and their families and carers.
- Must ensure that patients and carers are helped to make their **voice heard** both nationally and in their local communities.
- Should share best practice with health, social care and housing professionals and practitioners working with older people.
- Should support local organisations to deliver evidence based falls and fracture prevention exercise services.
- The National Osteoporosis Society will provide **caring support** to patients and carers of patients with or at risk of falls and broken bones.

General Practitioners

- Must satisfy the criteria required for their practices to achieve the payment associated with the osteoporosis indicators in the **2012/13 QOF**; this should be the **minimum** level of service that they provide to older patients at risk of broken bones.
- Should use the new commissioning responsibilities proposed for them to press for comprehensive falls and fracture care pathways to be designed, funded and implemented in their local areas.

Other healthcare professionals

- Must treat and care for people who have suffered and/or are at risk of falls and broken bones upholding **best practice standards** of care set out by the royal colleges, the professional and patient societies, NICE and the DH.
- Should record and **code** falls *and* resulting injuries in older people correctly.
- Must **refer** patients on to NHS, social care services and other agencies which can help to identify and reduce falls and fracture risk; mental health.
- Where they have prescribed treatments to reduce a patient's risk of falling or breaking a bone, they should ensure that their medication is reviewed on a regular basis.

Residential and nursing care homes and social care professionals

- Must help service users who have been prescribed bone-protecting medication to **take their treatment properly and at the right times**.
- Should ensure that residents who have fallen or who may have suffered a fragility fracture (which may include vertebral fractures, signified by back pain and height-loss) are **referred to NHS services**.

Ambulance trusts

- Must ensure that all ambulance staff record all incidences of falls and broken bones in older people, **whether or not they are conveyed to hospital**.

Pharmacies

- Where they undertake **Medicines Usage Reviews (MURs)**, pharmacies should ask if older patients have fallen recently; this question should be printed on repeat prescriptions; they must report their results back to patient's GPs.

Organisations which provide health, social care and housing services

- Should provide care to hip fracture patients which is consistent with the **Best Practice Tariff for hip fracture**.
- Must provide regular and accurate data to the **NHFD** and other national falls and bone health audits.
- Should **audit** the quality of care that they provide.
- Must ensure that their employees record and **code** falls *and* resulting injuries in older people correctly; providers cannot improve what is not measured.
- Should **share examples of best practice** (where highlighted by audit) with other provider organisations.
- Must do their utmost to prevent, identify and act upon falls and falls-related injuries among **inpatients** and individuals in their care; this includes creating safe environments for patients and service users, whether in hospital, residential or nursing care or their own homes.

Commissioners of health, social care and public health services

- Should commission a comprehensive **local falls and fractures prevention care pathway** based on existing prevention models developed by the DH and underpinned by NICE guidance; this must

involve a range of professionals from a number of health and social care settings, in addition to patients and carers in this process; their pathways should take primary and secondary falls and fracture prevention into account, with particular focus on non-hip fractures, which are often a precursor to a life-threatening and costly hip fracture later in life; pathways must include rehabilitation and reablement services for fragility fracture patients - this is required by the 2011/12 NHS Outcomes Framework.

- Must utilise the funding that was set aside for reablement in the **2010 Comprehensive Spending Review** for the benefit of falls and fracture patients.
- Should commission **local public health campaigns** which seek to reduce falls risk, improve bone health and raise awareness of what to do if an older person falls.
- Must **share examples of best practice** (where highlighted by national audits) with other commissioning consortia, regionally and nationally.
- Should **withhold reimbursement** from provider organisations which are not delivering desired outcomes or working to provide evidence-based services consistent with national guidance on falls and fracture prevention.
- Must ensure that older people (particularly those identified as being at risk of falls and fractures) have their **medicines reviewed** on a regular basis.

Health and wellbeing boards

- Should ascertain how many older people are admitted to hospital for falls or broken bones within their local area; they must include these data and an outcomes target to slow the rise in their incidence in their **local health and wellbeing strategy**.
- Should assemble a **multidisciplinary falls and fractures care network** for health and social care professionals in their area.

The Care Quality Commission

- Must hold to account consortia which are not commissioning falls and fracture care pathways.
- Should hold to account NHS and social care providers which are not offering care which is consistent with national guidance.
- Must examine contracts which are in place between commissioners and providers of NHS and social care services to ensure that falls and

fracture prevention is included; should hold to account providers who do not have robust protocols in place for preventing, identifying and acting upon inpatient or resident fallers.

Department of Health and/or the NHS Commissioning Board

- Must include indicators which measure hospital admissions resulting from falls and/or fractures in older people in the NHS, adult social care and public health **outcomes frameworks**.
- Should commission a **real-time national falls and fractures database**, incorporating the NHFD and the National Audit of Falls and Bone Health in Older People.
- Must provide **financial incentives** to commissioning consortia and Local Authorities for the outcomes they achieve in slowing the rise in falls and fractures in older people.
- Should provide national guidance on the correct **coding** of falls and falls related injuries.
- Must commission NICE to develop a **Quality Standard** on fractures (excluding head and hip) as soon as possible.
- Should promote comprehensive falls and fracture services to the NHS as a means of achieving the **QIPP** challenge.
- Must provide a forum for hosting **best practice** examples of local care pathways.
- Should ask NICE to initiate a **Clinical Guideline** on the management of fragility fractures at sites excluding the head and hip.
- Must ensure that each health and social care community has a number of **professional 'champions'** to spread best-practice among their peers; this would apply to all the professional disciplines which are part of a falls and fracture care pathway.

Chapter five: next steps

Partners have agreed to the need for a new commissioning toolkit. The National Osteoporosis Society and Age UK also propose that all organisations with a stake in improving the prevention of falls and fractures among older people sign up to a National Falls and Fractures Declaration.

All signatories would be invited to submit an action plan, describing how they will implement the declaration. Progress against each action would need to be monitored and assessed by a forum representing delegates from the summit. This would meet on a regular basis. Using the National Dementia Declaration as a precedent, we recognise that a resource commitment would be required from partner organisations to ensure:

- That the declaration is well promoted
- That it is signed by all appropriate stakeholders
- That it is being implemented by signatories
- That signatories meet on a regular basis to discuss progress and resolve issues as they arise.

Each signatory organisation would set out what it intended to do by 2017 in order to deliver their relevant section of the declaration. These plans will be published separately.

Organisations signed-up to the National Falls and Fracture Declaration would commit to making public information about what they are doing to deliver better quality of life for people with or at risk of falls and fractures. They would be expected to widely publicise their contribution to the declaration, especially to people with osteoporosis and/or who have suffered falls and fractures, carers and the organisations representing them. In this way organisations could be held to account in ensuring that they deliver what they have signed-up to. There would be an annual report to enable regular appraisals of progress.

Appendix one: the organisations represented at the Falls and Fractures Summit held at The King's Fund on 4 October 2011

Ms	Hilary	Arden	Training & Professional Development Manager	National Osteoporosis Society
Miss	Juliette	Brown	Communications and Public Affairs Director	National Osteoporosis Society
Mr	Paul	Burstow MP	Minister of State for Care Services	DH
Ms	Amy	Charters	Development Officer - Health	Age UK
Mrs	Cathy	Churchman	Osteoporosis Nurse Specialist	Weston Area Health NHS Trust
Mr	Gavin	Clunie	Consultant Rheumatologist	Ipswich Hospital NHS Trust
Ms	Rose	Cofie		DH

Mr	James	Cooper	Political Relations Officer	National Osteoporosis Society
Dr	Alun	Cooper	GP	Bridge Medical Centre, NHS West Sussex
Dr	John	Davison	Consultant Physician, Falls & Syncope Service	The Newcastle upon Tyne Hospitals NHS Foundation Trust
Ms	Zoe	Foan	Clinical Specialist Occupational Therapist	College of Occupational Therapists Specialist Section
Dr	Richard	Griffiths	Consultant	Faculty of Pain - Royal College of Anaesthetists
Dr	Karen	Harding	Orthogeriatrician	British Geriatrics Society
Ms	Nicky	Hayes	Adviser in Older People's Care	Royal College of Nursing
Mrs	Gail	Hebert	Patient representative	National Osteoporosis Society

Ms	Heléna	Herklots	Services Director	Age UK
Mr	Gerard	Hetherington	Senior Responsible Officer and Director-Clinical Policy and Strategy Division	DH
Ms	Janet	Husk	Programme Manager, National Falls and Bone Health Audit	Royal College of Physicians
Ms	Lorraine	Jackson	Senior Policy Manager, Older People and Dementia, Social Care Local Government Care Partnerships	DH
Dr	Raymond	Jankowski		The Association of Directors of Public Health
Mr	Bill	Jennings	Local campaigner	National Osteoporosis Society
Ms	Rachel	King	Physiotherapist and Falls Coordinator	NHS Tower Hamlets
Mrs	Rosemary	Leaf	Patient representative	National Osteoporosis Society

Ms	Anne	Macleod	Head of Fragility Fractures Programme & Clinical Audit NHS Medical Directorate - Clinical Policy & Strategies Division	DH
Dr	Finbarr	Martin	President	British Geriatrics Society
Ms	Karen	Middleton	Chief Medical Professions Officer	DH
Professor	Chris	Moran	Professor of Orthopaedic Trauma Surgery	Nottingham University Hospitals NHS Trust
Ms	Mary	Newman	Head of Clinical Strategies	DH
Professor	David	Oliver	National Clinical Director for Older People	DH
Mrs	Eileen	Page	Chair	Leeds Osteoporosis Support Group
Ms	JoAnne	Panitzke Jones	Senior Commissioning Manager	Torbay Care Trust

Dr	Steve	Parry	Clinical Senior Lecturer/Consultant, Institute for Ageing and Health	Royal Victoria Infirmary, Newcastle University
Mrs	Maggie	Partridge	Programme Manager	National Hip Fracture Database
Ms	Margit	Physant	Policy Officer - Health and Wellbeing	Age UK
Dr	Sue	Poulton	Consultant Physician for Older People	Portsmouth Hospitals NHS Trust
Ms	Alison	Raw	Lead Occupational Therapist, Adult Social Care	Surrey County Council
Mrs	Marion	Scott	Chair	Northampton Osteoporosis Support Group
Mrs	Claire	Severgnini	Chief Executive	National Osteoporosis Society
Ms	Christine	Sharp	Patient representative	National Osteoporosis Society

Ms	Maxine	Siddon	NHS Medical Directorate, Clinical Policy and Strategies	DH
Mr	Steve	Smith	Public Affairs Officer	WRVS
Dr	Kevin	Stewart	Medical Director	Winchester and Eastleigh Healthcare NHS Trust
Ms	Angela	Thornhill	Member	Nottingham Osteoporosis Support Group
Professor	Keith	Willett	National Clinical Director for Trauma Care	DH
Mr	Ian	Willmore	Head of Campaigns	Age UK
Dr	Jane	Youde	Co-Chair, Falls & Bone Health Section	British Geriatrics Society