THE SCOTTISH ENHANCED SERVICES PROGRAMME FOR PRIMARY AND COMMUNITY CARE (2007-2009)

Falls Prevention and Bone Health

Service Specification

Rationale

The "Delivery Framework for Adult Rehabilitation and Prevention of Falls in Older People" (HDL (2007) 13, February 2007) specified that, as part of the implementation of the NHS Boards rehabilitation framework:

NHS Boards need to develop a combined falls prevention and bone health strategy.
CHPs need to develop an operational combined falls prevention and bone health implementation strategy, working within the NHS Board strategy and any wider Community Planning strategy.
CHPs need to appoint a falls prevention co-ordinator to work alongside the overall rehabilitation co-ordinator.

This HDL can be accessed, along with the Rehabilitation Framework document via the following link: http://www.sehd.scot.nhs.uk/mels/HDL2007_13.pdf

There will also be a national falls project manager in place, funded through NHS QIS, and explicit links to this person should be made.

There is strong evidence that up to 30% of falls in older people living in the community can be prevented through comprehensive multidisciplinary and multi-agency interventions.

Older people who fall are at increased risk of fractures and injuries; hypothermia with consequences such as admission to hospital; loss of confidence affecting activities of daily living; increasing dependency with inability to remain in their own home or becoming housebound.

Once a person has fallen, they are at increased risk of further falls so it is timely to assess all older people after a fall to remove any preventable causes and minimise the risk of another fall.

In addition, in men and women aged 60 years or more who have a fracture, measures to improve their bone health can reduce future fractures. (SIGN guideline 71 and NICE Clinical Guideline 21- see links below).

Aims

This Enhanced Service will support the development and implementation of the NHS Board strategy on falls prevention and bone health through CHPs.

This Enhanced Service will identify patients of 60 years and over who have fallen, with or without a resulting fracture.

This Enhanced Service will identify those patients at risk of further falls and those who present with risk factors relating to bone health

This Enhanced Service will then provide interventions which can be managed in Primary/ Community care which will prevent fractures and reduce the impact of falls in this patient group.

This Enhanced Service will then, when required refer patients on through an identified care pathway to falls and fracture prevention services which will follow the NHS Forth Valley Falls and Fracture Prevention and Bone Health Guidelines

Brief Description of Service

The Enhanced Service will contribute to the development and implementation of a care pathway for management of patients aged 60 and over who have fallen, in order to reduce their risk of future falls. If a fracture has been sustained as a result of the fall, the care pathway will include steps to reduce the patient's risk of future fractures by improving bone health and reducing the impact of the falls.

This will involve a multi-disciplinary and multi-agency approach, both in the development of the care pathway, its implementation and the dissemination of up to date information about the care pathway and clinical guidelines in the management of osteoporosis.

A single point of access to falls and fracture prevention services will be developed alongside the care pathway.

A Falls register will be developed by Practices to identify those patients who have fallen and will include notification of falls to the Primary/Community services. This will prompt early screening of patients for risk factors and immediately set them onto the care pathway.

The Falls register will be linked to and compatible with existing systems; GPASS, EMISS and VISION and will include a comprehensive dataset, which will contain relevant information related to risk factors, interventions and outcomes.

In addition a checklist will be developed for use by the Practice team indicating activity associated with the SESP. .

A simple screening tool will be developed for use by Practices, which will identify patients who require assessment for identification of risk factors.

Education relating to Clinical Guidelines in Osteoporosis and Falls management, the care pathway, the falls register, screening and assessment, will be incorporated into the Enhanced service.

Service Specification
Practice Teams will: (i) Record their attendance at Enhanced services education seminars. (ii) Record on the Practice Held Falls Register those patients at risk of falls or at risk of fracture due to predisposing factors. (iii) Record patients who have full assessments conducted in relation to identified risks. (iv) Record referrals made to other services. (v) Record interventions and investigations completed. (vi) Record outcomes of interventions. (vii) Identify relevant Staff to conduct initial assessment of patients who have fallen and are notified as fallers. **E-Health will:** (i) will develop existing IT systems to incorporate a falls register which will include mechanisms for reporting on agreed outcomes. (ii) E-health will develop hyperlinks which link the register with existing protocols and guidelines related to falls and bone health. (iii) E-health will provide training and education for practices in the use of IT systems. **Community Pharmacists will:** (i) Identify patients on bone health medication and audit medication compliance. (ii) Provide education on bone health medication to those patients who require it. (iii) Identify patients on medications which increase their risk of osteoporosis; target medication will be steroids. (iv) Audit this target group of patients on steroid therapy. **Also:** • A screening tool will be developed by the Multi-agency Falls and Fracture prevention Strategy group for use by the Practice teams • The **Falls Strategy Group** will provide representation for training and education in the use of the screening tool and care pathways • An Assessment protocol will be developed by the Multi-agency Falls/Fracture prevention Strategy Group • The Care Pathway will be developed further by the Strategy group and will reflect the SESP. Education relating to the SESP will be arranged by the Enhanced Services Group. Local staff who have been involved in developing the register, clinical guidelines, care pathway, screening and assessment tools will deliver this education. It is anticipated that this will be through a launch of the SESP in 2 evening and lunch time seminars.
Expected Outcomes
It is anticipated that the Enhanced Service will identify Fallers at the earliest opportunity and then direct those patients onto a clear pathway consisting of evidence based screening, assessment and multi-agency interventions. There will be a resulting increased awareness of best practice in relation to falls and fracture prevention, including best practice in relation to bone health and health promotion. The Enhanced Service will endeavour to screen, assess and treat within the Primary/Community setting and refer on only those patients who are appropriate to do so and who require more specialist services.

A single point of access to Falls and Fracture prevention services will result in reduced transitions between teams and more appropriate evidence based interventions.

It is expected that the Enhanced Service will, through the process of screening, assessment and intervention, have an impact in reducing those falls which can be prevented and also reduce the impact of falls caused by fragility.
This would help reduce potentially long stay hospital admissions and may also prevent admissions in some cases.

It is expected that referrals for DEXA scanning for those patients under 75 years may increase and that referrals for those of 75 years and over may decrease

It is expected that prescribing patterns will alter, resulting in more appropriate prescribing of medication for Bone health.
In the longer term it is anticipated that a reduction in fragility fractures will result.

Heightened awareness of Falls will result in an increase in reporting in the short term.

How outcomes will be measured locally and the process evaluated

All Practices locally will be asked to confirm they have received and understood guidelines and protocols in relation to the SESP.

The impact of the Enhanced Service will be measured utilising the reporting system incorporated in the falls register.
The following data will be collected;

- Numbers of patients who have fallen; any resulting injury will be recorded
- Numbers of patients identified with risk factors; risk factors recorded
- Numbers of patients who are then fully assessed by Practices according to the protocols given.
- Numbers of patients referred on to other services; these services will be specified
- Number of new patients being prescribed medication for bone health; medication will be specified
- Number of patients who have had Bisphosphonates stopped as the result of medication review.
- Numbers of patients sustaining fractures following interventions will be recorded
- Evaluation against national figures for Falls and Osteoporosis will be used to demonstrate the impact of the DES
- Attendance register will be taken at the education seminars.
- It is anticipated that the data collection identified will be capable of measuring the impact of the DES , in terms of increased referrals to other services.

Summary and Breakdown of Final Costs

Training costs for AHP staff includes provision of training for those staff groups associated with assessment and delivery of evidence based interventions. It also includes Staff with specialist knowledge delivering training to others in the Primary care/ community teams at launch events and targeted training sessions.

E-health for set up of a falls register and support of the register including reporting and analysis

Costs for GP practices have been based on anticipated work load increases and have been calculated by offering an engagement fee initially and then a maintenance fee thereafter.

Workload increases for Community Pharmacists.

Health education materials for patients who have fallen and/or have bone health issues.

There is the potential through more appropriate prescribing to make substantial savings in the longer term, specifically in the 60-74 year old population, though in the 75 plus age group prescribing may increase.

Payments to General Practice

- Engagement Payment: £500 / practice (to be paid March 2008)
- Maintenance Payment: £200/practice /3 months from April 2008
- Final Payment £150/1000 registered patients/year

Payments to Community Pharmacy

Engagement Payment £200/pharmacy (to be paid March 2008) in recognition of additional risk assessment, health promotion and medication review required through the implementation of the SESP.

Further Information

SIGN Guideline 56 – Prevention and Management of Hip Fracture in Older People
http://www.sign.ac.uk/guidelines/fulltext/56/

SIGN Guideline 71- Management of osteoporosis
http://www.sign.ac.uk/guidelines/fulltext/71/index.html

NICE Clinical Guideline 21 on Falls: the assessment and prevention of falls in older people
http://www.nice.org.uk/page.aspx?o=233391

Guideline for the Prevention of Falls in Older Persons by the American Geriatric Society
http://www.americangeriatrics.org/products/positionpapers/Falls.pdf

WHO Falls Strategy (information available on the WHO website) http://www.who.int/en/