Health and Wellbeing
SUFFOLK

Agenda Item 5

Suffolk Health and Wellbeing Board

A committee of Suffolk County Council

Report Title:	Falls, Fractures Fragility Care and Prevention in Suffolk
Meeting Date:	10 September 2014
Chairman:	Councillor Joanna Spicer
Board Member Lead(s):	Julian Herbert, Andy Evans, Anna McCreadie
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Brief summary of report

1. The purpose of the paper is to provide an overview of Falls, Fragility, Fracture Prevention and Care in Suffolk including the Ipswich and East Suffolk Clinical Commissioning Group (IESCCG), West Suffolk Clinical Commissioning Group (WSCCG) and Great Yarmouth and Waveney Clinical Commissioning Group (GYWCCG).

Action recommended

2. The Board is asked to endorse the on-going work described in this report, the objectives of which are to reduce the number of falls and fragility fractures in Suffolk, and to improve the care of those frail patients who do suffer falls and injuries.

Reason for recommendation

3. To be successful in driving forward the Integrated Falls, Fracture, Fragility care and Prevention programme to support the Suffolk Health and Wellbeing Board strategic plan; IESCCG, WSCCG and GYWCCG are keen to work with partner organisations and networks to facilitate a truly collaborative and integrated approach in the delivery.

Alternative options

4. None identified.

Who will be affected by this decision?

5. The elderly frail population of Suffolk.

Main body of report

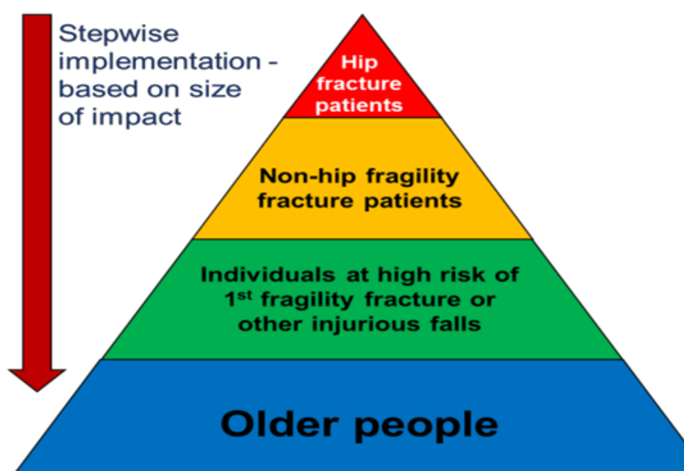
6. The IESCCG and WSCCG's shared vision for the Falls and Fragility Fracture prevention and care is to ensure we, as a local health system, implement the four objectives set out in the Department of Health's (DoH) 'Systematic Approach to Falls and Fracture Prevention'. In doing so, create pathways of care that are integrated and orientated around the needs of our local patients and their family carers, evidence-informed, and offers compassionate quality care to Suffolk's most frail and elderly.

7. The five objectives highlighted below are set out in the IESCCG and WSCCG's Strategy for **Integrated Falls and Osteoporotic Fragility Fracture Prevention and Care** published in February 2014 and sits beneath a wider set of local and national health and social care policies and outcome frameworks. It is, therefore, important to place this strategy in its widest context for the benefit of organisations involved in the implementation of this work, specifically Outcome 3 of the Joint Health and Wellbeing Board Strategy for Suffolk '**Older people in Suffolk have a good quality of life'** – makes reference to the following measurable indicators; decreasing falls and injuries in the over 65s and decreasing hip fractures in over 65.

Key Objectives

8. The key objectives are:

   a) To improve patient outcomes and improve efficiency of care after hip fractures
   b) To respond to a first fracture and prevent the second – through fracture liaison services in acute and primary care settings
   c) Early intervention to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries
   d) To prevent frailty, promote bone health and reduce accidents – through encouraging physical activity and healthy lifestyle, and reducing unnecessary environmental hazards
   e) To decrease permanent admissions to residential and nursing care homes



9. The GYWCCG's vision can be described as: 'By 2018/19 the citizens of Great Yarmouth and Waveney will receive their health and social care, and some district/borough services, from a cohesive Integrated Care System (ICS) acting as a single provider of services. The ICS will be user focused, delivering high quality and safe services with an orientation to innovate and develop new methods delivering better care based on the ideas and ambitions of professionals and the feedback of users. Because it is operating in a coordinated way, eliminating inefficiency and waste, and striving for more effective delivery methods it will be using resources optimally and constituent member organisations will be in financial balance and able to invest in further improvements.

Suffolk Population profile

10. Suffolk has a higher than average hip fracture rate; data from the National Hip Fracture Database (NHFD) mainly due to our population profile. A common and serious outcome of a fall is a fractured neck of femur. Hip fractures can have long-term consequences with only one in three sufferers return to their former levels of independence, and one in three leaves their own home and moves to long-term care. Hip fractures are almost as common and costly as strokes and the incidence is rising.

11. Over 10% of all older people admitted to hospital with a hip fracture during 2012/13 of which there were 460 in the East , 284 in the West and 1,200 in the Great Yarmouth and Waveney areas, went into long term residential care. Given our population profile these figures are expected to increase by 30% increase by 2020.

12. The East and West Suffolk Tricordant Review; found that falls are the leading reason for permanent admission to residential care with one in three people over the age of 65 years and half of those over 80 predicted to fall at least once a year. This equates to 19,000 falls in the over 65s and 11,000 falls in the 80s population in the Ipswich area, 17,000 falls in the over 65s and 3,200 in the 80s population in the East Suffolk area.

13. Fall-related injury is an issue that disproportionately affects women with the rate for females being 1,842 directly standardised rate (DSR) per 100,000 residents and only 1,066 for males. This is likely to be due to osteoporosis (thinning and weakening of the bones), which primarily affects older women because of as a result of the hormonal changes that occur following the menopause (and can also develop in men).

14. In 2012/13 there were 1,636 emergency admissions for falls in the over 65s to Ipswich Hospital with an associated cost of £4.6 million and in the West Suffolk area there were 1,023 emergency admissions with an associated cost of £3.3 million.

15. The East of England Ambulance Service Trust report that there are approximately 360 falls attended every month across East and West Suffolk; 20% of those are from Care Homes which represents a sixth of their overall activity.

16. In Norfolk in 2011/12 there were 3,644 people aged over 65 who were admitted to hospital with injuries due to falls. Between 2010/11 and 2011/12 the DSR increased from 1,345 per 100,000 residents to 1,454 per 100,000 residents; but this is still well below the national average and just below the regional average. Falls are estimated to cost Norfolk and Waveney health

and social care services around £19 million every year and this does not include a number of unknown costs such as GP time treating people who have fallen.

17. The National Institute For Health And Care Excellence (NICE) Falls: **Assessment and prevention of falls in older people 2013**, recommends multi factorial falls prevention programmes which can achieve substantial (15-30%) reductions in the incidence of falls amongst older people; interventions can be relatively simple i.e. strength and balance training and through redesign and better coordination of existing services.

18. It is in the context of these challenges, population profile and opportunities each CCG developed their strategic direction, approach and local delivery plan, identifying key areas of focus to meet the needs of their local population with some of the key highlights outlined as follows.

Ipswich and East Suffolk Clinical Commissioning Group

19. The strategy for East and West Suffolk was developed by the Integrated Falls, Fracture and Fragility Group, which came together in September 2013. The group; comprised of Health, Local Authority, patient groups and Voluntary sector organisations set out the direction of travel and proposed plan of work for the next 2-5 years following a six month intensive period of gap analysis, community engagement and in 'walking' the pathway. The key areas of implementation for 2014-15 are in the following areas utilising patient experience and feedback in their development.

Improved Pathways of Care:

20. A revised Ambulance Pathway has recently been developed for patients attended; this cohort of patients from September will now be referred directly to Suffolk Community Health Services for assessment.

21. The 'Audrey Falls' pathway for primary care **'Make Every Contact Count'** was developed following scoping of the current services and promotes the key interventions for anyone who comes in contact with someone who has fallen or at risk of. The Learning toolkit will be used as part of 'Lunch and Learn' session for Integrated Neighbourhood Teams during November.

22. WSCCG and IESCCG has been working with Suffolk Community Healthcare to ensure all patients who come into contact with local healthcare teams are asked about their falls history and are assessed for falls risk. (See Appendix1)

Electronic assessment and referral tools:

23. A multi-disciplinary electronic falls assessment for anyone on the caseload of Suffolk Community Health which can be shared between Primary Care, Community Health Services, Acute Trusts and Adult Social Services.

Community Strength and Balance Training:

24. A twelve innovative month 'Make a Move' partnership project with ActivLives , AgeUK Suffolk, Suffolk Careline and Suffolk Family Carers to encourage and support people to improve their own health and wellbeing, including user friendly information, social activity, allowing people to move smoothly between specialist falls rehabilitation programmes and community exercise sessions.

25. A ‘showcase’ Conference event is planned to take place in September 2015.

Web based Falls Directory of Services:

26. This is a standalone web based Falls Directory of Services; linked to partner agencies that is easily accessible to health professionals to signpost or refer patients onwards.

Increased Fracture Liaison Capacity:

27. The additional nursing capacity is being invested in the well-established Fracture Liaison Service to specifically follow up of hip fracture patients, at one, four and twelve months within the community.

Assisted Technology 24/7 Falls Response Service:

28. This six month pilot project, in partnership with Suffolk Careline aims to offer an eight week assisted technology discharge package to suitably assessed elderly patients to reduce risk of further falling, alert health sector a minor fall has occurred, prevent inappropriate admission to hospital and refer on to other services.

Multi-disciplinary Falls and Bone Health Training and Education programme

29. Now in its second year, The Falls and Bone Health Conference in partnership with the National Osteoporosis Society will take place in September, open to allied Health professionals, Care Homes and community staff. An Education and Training event for Practice Nurses and Care Homes staff was facilitated in May, led by Dr Julie Brache, Consultant Geriatrician; a further event will take place in October with rolling programmes scheduled to take place in 2015.

Primary Care training ’Making Every Contact Count ’screening and risk stratification

30. Dr Julie Brache will be the key note speaker at the Education and Training event for General Practitioners in October. Her key messages will be focused on the importance of good history taking, medication review and that falls are seen as a symptom and not a diagnosis.

Medicines safety and poly-pharmacy:

31. The Primary Care Prescribing Incentive Scheme implemented in July, sets out to raise awareness on which drugs are likely to contribute to the risk of falling and poly pharmacy and encourage primary care to regularly review and amend medications where clinically appropriate.

Public Awareness Health Campaigns

32. During Falls Awareness week in June; IESCCG offered taster Otago sessions to the public, provided in-reach chair based sessions to three local care homes, manual handing training to Suffolk carers and a free eight week trial of the Assisted Technology package and a health supplement on out local papers.

33. In partnership with Public Health Suffolk and Livewell Suffolk, IESCCG and WSCCG have developed a six week campaign focused on activity and health messages for 50-65year olds ‘**Use it or Lose it.**’

West Suffolk Clinical Commissioning Group

Fragility fractures and falls prevention

34. The WSCCG works closely with their counterparts at IESCCG to ensure that the strategic direction to support the reduction of falls in the community. The main areas of activity for West Suffolk over the last 18 months have been the continued development of the West Suffolk Integrated Fracture Liaison Service (WSIFFLS), ensuring all patients are assessed for falls risk and the establishment of a falls prevent exercise programme.

35. The aim and overarching principle of the WSIFFLS is to prevent the second fracture by responding appropriately to the first. All patients over 50 years with a fragility fracture have a comprehensive falls and bone health assessment, are referred for appropriate investigations and interventions, and monitored for compliance with osteoporosis medications. The service has undertaken case-finding, created clinical pathways to standardise care, helped GP practices establish falls registers, and trained GP clinical staff to deliver an initial falls screen for patients. All house-bound and 24 hour care home residents who were identified on the GP falls registers have been assessed.

36. The service continues to progress its exposure and associated access across General Practice, strengthening links with Suffolk Community Healthcare to ensure the patient receives the appropriate assessment at the right point on their pathway, and establishing a virtual bone clinic for complex patients.

37. A further part of the wider falls prevention programme in West Suffolk has been to establish and extend the provision of Otago falls prevention exercise classes. Working with Age UK Suffolk on a project named Positive Steps, we have been able to map existing classes, extend the number of qualified trainers and expand the availability of classes has been developed. The number of trainers has increased from 5 to 19 and the number of weekly classes from 5 to 29. Weekly attendee numbers are up from c55 to c285. Good relationships have been established with local authorities, community healthcare teams, housing providers and others.

38. The social aspect of the classes is important with many offering time for refreshment and socialising which has enhanced the patient experience. The outcomes of the classes have been overwhelmingly positive and some case studies relating to the scheme are attached to this paper in Appendix 2.

39. The IESCCG and WSCCG's are committed to continue to work in partnership with organisations working with older people to ensure falls and fractures are not seen as a consequence of ageing; continue to build on the good work undertaken to date and achieve better outcomes for our elderly population, specifically;

    - Reducing the risk of falling
    - Reducing the risk of fracturing
    - Reducing social isolation and promote independence
    - Improving health and wellbeing
    - Promoting a positive approach to healthy ageing

40. For further information please contact shivaun.aveston@ipswichandeastccg.nhs.uk in the Ipswich and East Suffolk and lee.taylor@westsuffolkccg.nhs.uk in the West Suffolk area.

Great Yarmouth and Waveney Clinical Commissioning Group (GYWCCG)

41. Falls prevention services in Norfolk and Waveney are currently provided by two organisational bodies. East Coast Community Healthcare (ECCH) provides services for Great Yarmouth and Waveney and Norfolk Community Health and Care (NCHC) are the provider for the rest of Norfolk. In both of these organisations falls assessments and prevention interventions are carried out by integrated teams, made up of community occupational therapists and physiotherapists with links to social care. There is not a specific, stand alone, 'falls prevention service'. Commissioners are advised to recognise importance of Falls Prevention services and commit to ensuring consistency of funding for the services in the future, for the whole county.

42. There is a 'Falls Prevention Steering Group' co-ordinated by Norfolk County Council (NCC) Public Health, which meets regularly to discuss falls prevention at a countywide level; this is supported by a group in each of the Clinical Commissioning Group (CCG) localities and is attended by a wide range of partners across health, social care, district councils, healthcare providers and voluntary sector organisations.

43. The 5 Year Strategic Plan describes Great Yarmouth and Waveney CCGs move towards and Integrated Care System (ICS). In conjunction with our commissioning partners, Norfolk County Council (NCC), Suffolk County Council (SCC), Great Yarmouth Borough Council (GYBC), Waveney District Council (WDC) and NHS England (in respect of the direct commissioning of primary care) Great Yarmouth and Waveney CCG has worked up and agreed a common vision of an Integrated Care System (ICS) as a means of ensuring the provision of quality care to all of GYW population, ensuring integration of pathways rather than the current fragmentation, increasing the efficiency and effectiveness of the care provided to GYW population, as well as maximising scarce resources. These are the founding principles of GYWCCG drive towards integration.

44. CCG Operating Plan for the 2 years (linked to the above 5 Year Strategic Plan) has falls management as a highlighted work stream. This includes:

- Development of an Integrated Falls Service across GYW delivering multi-disciplinary intervention programmes for the effective prevention of falls.
- Early identification and treatment within primary care including early assessment of bone health and those with a tendency to fall.
- Primary and secondary fracture liaison services.
- Increased geriatrician support with a dedicated multi-disciplinary clinic which will support a best practice model.

45. Expected outcomes include:

- Benefits from a GYW Integrated Falls Team.
- One team working for the benefit of the patient irrespective of organisational boundaries.
- A shift from reactive to proactive provision across all providers.
- Seamless service for patients with improved integration across service areas.
- Improved patient experience.
- Increased senior clinical leadership with specialist support.
- Shared learning, knowledge and expertise across services and improved networking with primary care.
- Reduced A&E attendances.
- Reduced numbers of emergency admissions and readmissions to acute and community beds.
- Reduced number of fractures.

46. Please contact bob.purser@nhs.net for further information

Sources of Further Information

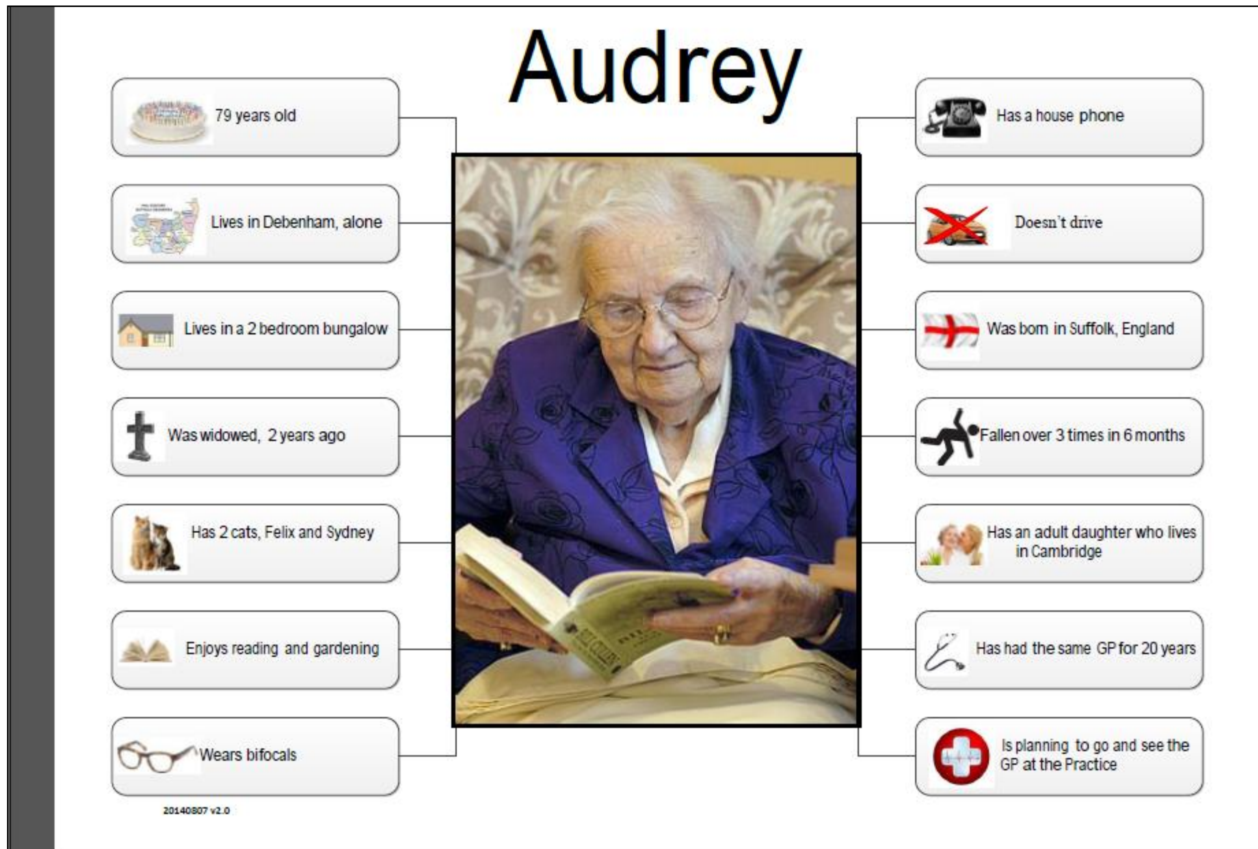
The following documents are available on request from the relevant clinical commissioning groups:

Great Yarmouth and Waveney Clinical Commissioning Group - Extracts from Health Needs Assessment - Falls Prevention in Norfolk

West Suffolk Clinical Commissioning Group - A Proposed Strategy for Integrated Falls and Osteoporotic Fragility Fracture Prevention and Care 2014 – 2019

Ipswich and East Suffolk Clinical Commissioning Group - A Proposed Strategy for Integrated Falls and Osteoporotic Fragility - Fracture Prevention and Care - 2014 - 2019

Audrey Falls 'Make Every Contact Count' Pathway in Primary Care



Audrey Falls 'Make Every Contact Count' Pathway in Primary Care

NICE Guidelines 2013: People aged 65 yrs. >at high risk of falls and those 50-64yrs who are of high risk of falling and diagnosed with an underlying condition, should have a multi factorial assessment

Department of Health 2009 Systematic Approach to Falls and Fracture Prevention Falls, Fracture Prevention and Care

Improve outcomes after hip fracture

Respond to a first fracture, prevent the second

Early intervention to restore independence

Prevention of bone frailty, promote bone health and reduce accidents

***Onward Referral**

Allied Health Professionals

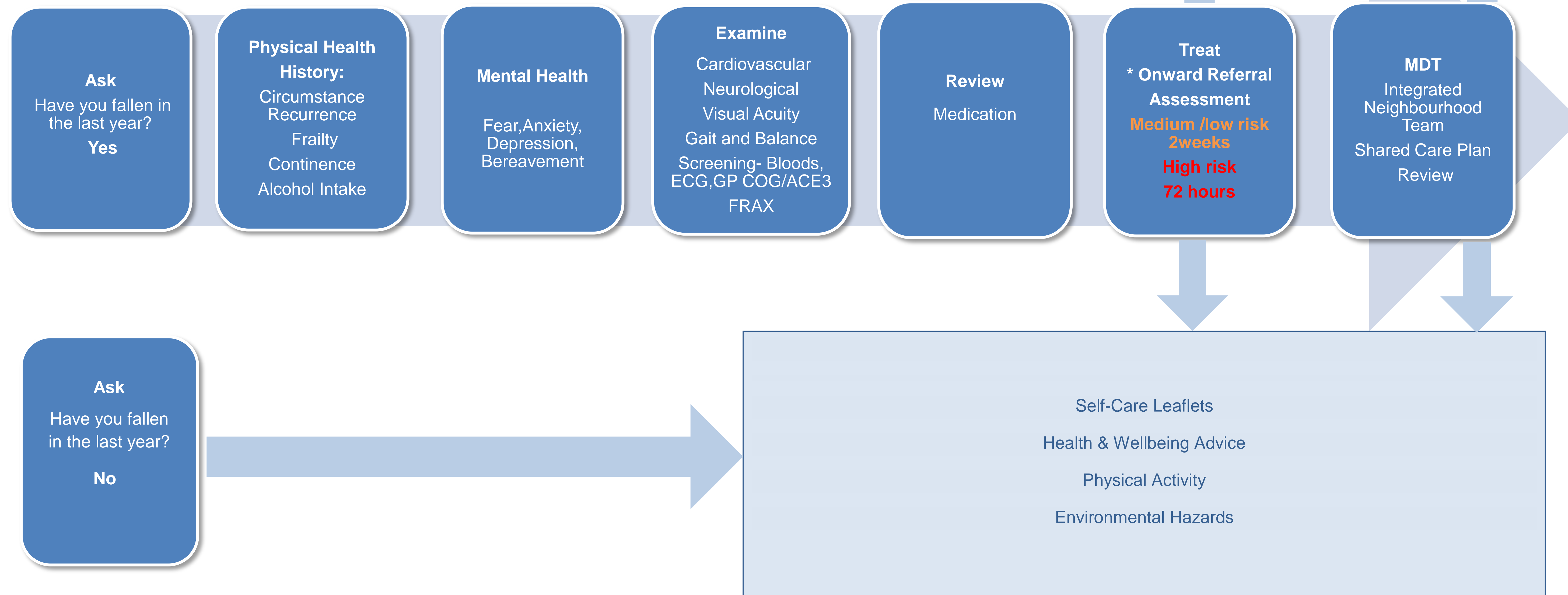
Interface Geriatrician- CGA, Falls Clinic/Hot Clinic

Care Coordinating Centre-Multi Factorial Assessment

Adult Community Services

Voluntary Services- Age UK, Suffolk Family Carers, Suffolk Careline, ActivLives

Falls Directory of Services



Audrey Falls- MECC Pathway for Primary Care v1.3

Appendix 2

Otago falls prevention exercise classes, West Suffolk

Patient stories:

Case study 1:

1. Female age 86 lives independently in sheltered accommodation. Does not drive. Started attending a community based Otago Falls Prevention Exercise Class in 2012. In August 2013 fell inside broke neck of right femur.
2. Instructor called to ask how she was 3 weeks after operation and visited client. Low morale as she felt that she could not leave home and could not see herself returning to the class. To prevent further falls instructor asked client to throw ‘comfortable shoes’ away as they had no grip on souls and were a hazard. Client was also having care visits up for 4 weeks to help with personal care. Iris did not enjoy having help with shopping and laundry and she was always intent on regaining her independence. Instructor contacted Fracture Prevention Nurse Specialist who arranged to see client and had already received notification about this lady from the local hospital. Client could not remember the drugs that she should continue to take. Fracture Prevention Specialist Nurse performed a bone health and falls prevention assessment, along with offering healthy life-style advice and information. Instructor phoned again 4 weeks later and invited client to class. Client attended and was really pleased to be out of the house.
3. Client now independent and mobile and attends class every week. Balance is much improved as indicated by the ‘no hand needed berg balance test’. Now much happier, independent with no carers and is amazed at how well she is doing, especially in the garden and singing in choir.

Case Study 2:

4. Female 86 living in own home on own – fell during the spring on 2013. Now this lady fears falling again, has lost her confidence and is staying at home more. She was unable to tend to garden much as now relying on stick.
5. November 2013 Otago instructor meets client at home who starts exercises, given weights and asked to repeat 3 times a week. Instructor visits once a week.
6. April 2014 client now walking easily upstairs, tending to garden, now rarely uses stick. Client comments that her confidence in going out has grown and she is much happier because of this. Instructor says client is now achieving sit to stand without help and carries herself better when balancing and walking.
7. Both IESCCG and WSCCG recognise that in order to prevent people faller we need to make falls everyone’s business. This means making every contact count by ensuring patients/clients are routinely asked whether they have fallen in the last year and then taking action if the answer is yes. To ensure this happens people need to understand falls risks, what can be done to prevent falls and what actions can be taken after a fall to prevent further falls. To address this challenge WSCCG is working closely with Ipswich and East Suffolk Clinical Commissioning Group and other colleagues to develop a training programme and to raise awareness amongst the public through a public health campaign.