

Identification of patients who would benefit from Bone Health investigation and treatment in Croydon Community- 'widening the net'

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AIM

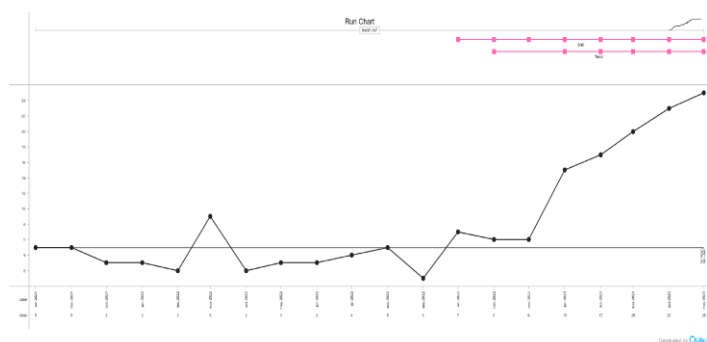
By June 2024, Community Therapy Teams will increase the identification of patients to be referred for bone health need to Falls and bone health, Fracture Liaison Service (FLS) by >50% compared with 70 patients referred during pilot stage September 2021 to January 2023.

As an extension and part of this uplift, additional work is being undertaken to try to raise awareness and identification also via the Integrated Care System linking in with GP's and the FLS. It is aiming to promote increased positive and proactive actions around bone health within primary and secondary care where indicated.

RESULTS

The run chart illustrates that since the commencement of the project, post pilot period in January 2023 there has been a sustained uplift in identification and referral of patients from Community therapy services. Through collaboration, the referral sources are more varied demonstrating good evidence of inclusivity with a range of patients from varied specialty areas, ie Neuro and Learning Disability services.

An ROS cost analysis suggests that there would be savings of £150,000 over a 5 year period based on the first 100 patients identified in this project. Now 178 patients in 20 months.



BACKGROUND & METHODS

During a previous Falls and Bone Health Practitioner role there was an awareness of unmet need locally within Croydon, for residents in the Community who go un-identified as requiring bone health assessment and potential treatment, so remaining at increasing risk of fracture.

Evidence shows a programme of targeted screening for women aged >70 for example would likely prevent 8,000 hip fractures annually, Royal Osteoporosis Society (ROS Feb 2022). The ROS 5IQ model illustrates that Identification is crucial to allow the correct onward care to be delivered for these patients, evidence also shows the benefits to being under care of an FLS.

Vertebral fractures are the most common type of fracture caused by Osteoporosis. People with these are at much higher risk of experiencing further fractures. Yet up to 70% of Osteoporotic vertebral fractures go undiagnosed/ 'missed'. Early identification and management can prevent further fractures, benefitting people living with osteoporosis and the NHS.

By the end of 2023, to have increased Community healthcare staff aware and trained to use the FRAX assessment tool for all patients who are >50 years of age who have been referred with or have sustained an uninvestigated recent or previous fragility fracture. This will embed FRAX as part of routine assessment where indicated, and prompt referral on for investigation and treatment accordingly. *The referral pathways are currently being developed.*

The above is being achieved through direct training and collaborations. PDSA cycles with regards to training are being implemented, a mini network has been set up to share knowledge and promote awareness. Collaborations have to date included the following teams: Community stroke, Community Neuro, LD, Domiciliary Physiotherapy, ICN+, LIFE, MSK, CCST.

CONCLUSIONS/RECOMMENDATIONS

The concept of this unmet bone health need in the Community proven. National guidance suggests healthcare services 'should recognize that fractures due to Osteoporosis are a significant and growing public health issue, with high health and social care costs, something that should be addressed explicitly in local healthcare programmes' -Integrated Care Systems, as per National Osteoporosis Guideline Group recommendation (NOGG 2021)

Next steps must include development of an 'end to end' bone health pathway including robust screening, embedding the use of FRAX and referral, ultimately maximizing identification across teams including ICS. We must shape services to address bone health for people living with Osteoporosis and at high risk of fragility fractures in Croydon and potentially SWL partners/peers, moving towards a 'one stop shop' for bone health through group consultation.

- Effective Secondary Prevention of Fragility Fractures: Clinical Standards for Fracture Liaison services (ROS) 2019
- National Osteoporosis Guideline Group (NOGG) guidelines: 2021

Improving Awareness & Early Identification of Bone Health needs in Croydon Community- the numbers.....

Educating Staff

- Increasing the number of staff and teams using FRAX assessment tool hence identifying and actioning referral for bone assessment including DXA
- Above being achieved through teaching sessions in person and virtually, sharing of info in networks, 5 different teams so far

Targeting Patients

- 70 patients previously referred Sept 21– Jan 23 in pilot phase.
- 108 patients referred in 5 months Jan – May 2023 demonstrates growth, but numbers can be far bigger as this work expands. 178 therefore referred in total to date
- Between 70-75% of identified patients from community go on to require treatment or bone intervention

Patient Engagement

- 130 referrals included DXA scan
- 34 awaiting DXA scan appts
- 14 DNA/declined/admitted 1 RIP
- Often has been an additional aspect of care delivered alongside therapy treatments
- Positive feedback, to be more formally collected

Patient Profile

- 79 average age of patients
- Average clinical frailty 5.1 potentially a tipping point stage of frailty so vital
- 33 male, 137 female
- A wide range of ethnic background, a project actively seeking inclusivity reaching out to range of teams, also included 5 care home residents at point of identification.



Cost Benefits

- £158,083 savings for first 100 patients identified, according to Royal Osteoporosis Society calculation over a 5 year period, majority of these 100 patients identified by one individual therefore demonstrating the wider potential with increased identification

Healthcare Impact

- £4,217 for Primary/community care
- £78,046 Acute Care
- £75,820 Social Care
- 196.8 bed days over the 5 years
- Can see that this is work that can contribute to relief of pressure on the acute setting

Prevention

- Reducing number of fragility fractures
- Group Consultation promotes self help
- Signposting and information
- Improved lifestyle bone management
- Potential knock-on effects on approach with management of other long term conditions

Future Proofing

- A public health issue which will grow
- Research & Best Practice influence
- Innovative forward thinking approach
- Included now in ongoing patient education in other community services, and added to assessment proforma
- Included now in yearly Nursing health checks in LD service