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

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AIM

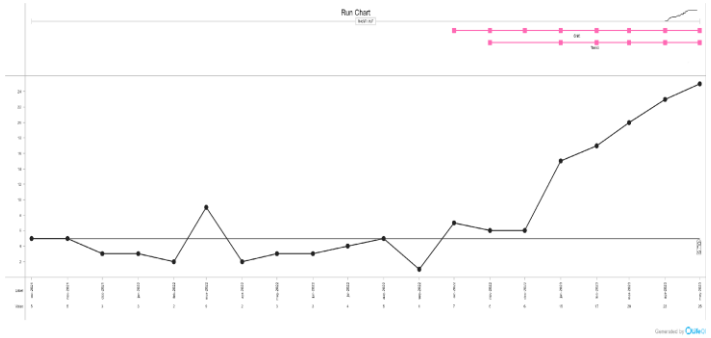
By June 2024, Community Therapy Teams will increase the identification of patients to be referred for bone health need to Falls and bone health, Fracture Liaison Service (FLS) by >50% compared with 70 patients referred during pilot stage September 2021 to January 2023.

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 anaylsis 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

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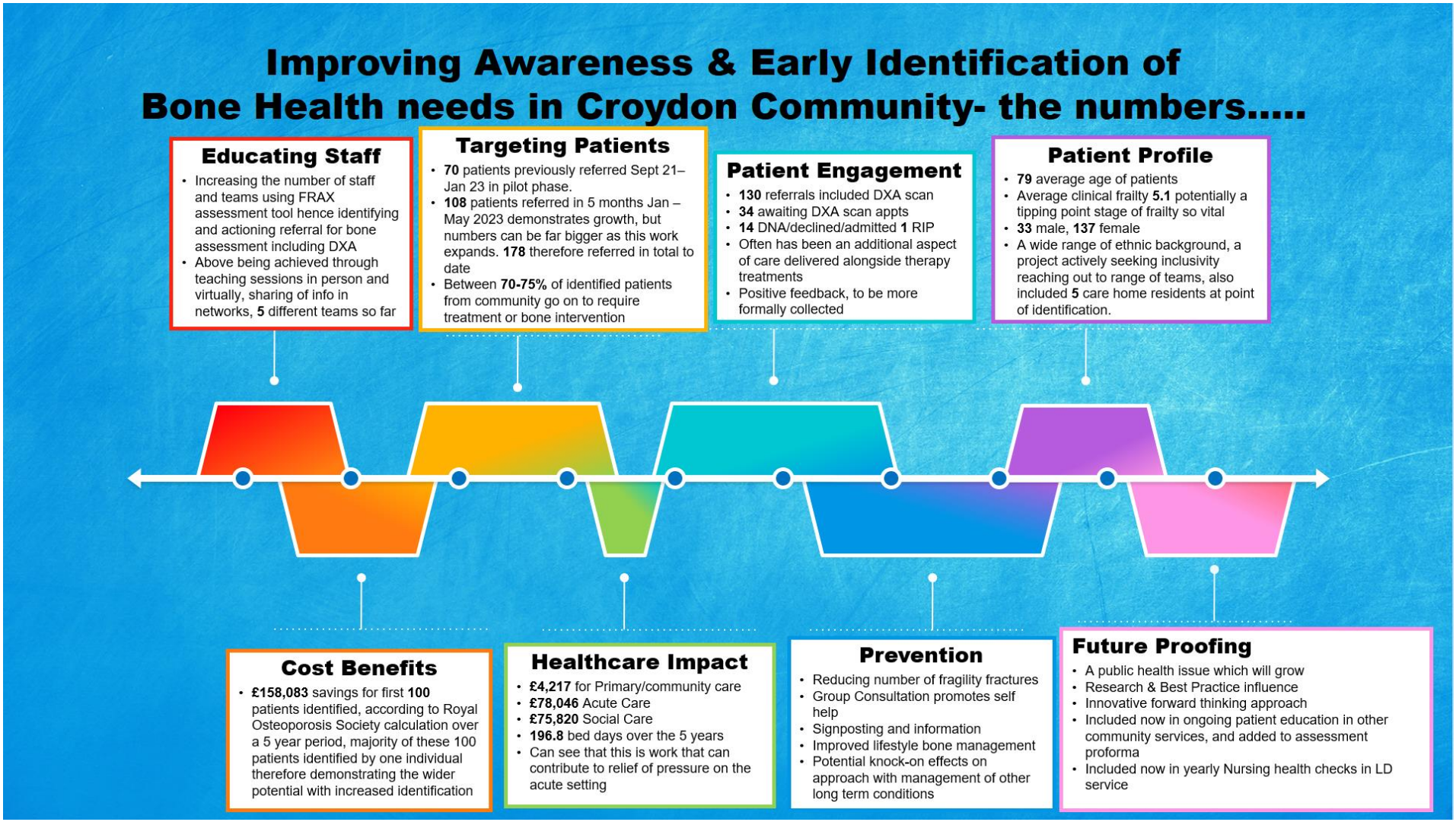
Improving Awareness & Early Identification of Bone Health needs in Croydon Community- the numbers.....



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