All Party Parliamentary Osteoporosis Group (APPOG)

Falling short: Delivering Integrated Falls and Osteoporosis Services in England

A report on the implementation of Standard Six of the National Service Framework for Older People

December 2004
Foreword

Osteoporosis affects a large number of people in England: one in two women and one in five men over the age of 50 will have an osteoporotic fracture of the hip, wrist or spine. Despite being recognised as a considerable public health problem, it is estimated that only a small proportion of patients receive preventive advice and treatment for their condition. Instead over £1.7 billion is spent mending osteoporotic fractures across the UK each year.

By 2003, APPOG was becoming increasingly concerned that the document charged with delivering fully integrated falls and osteoporosis services, the National Service Framework for Older People (NSF), was not being implemented in the manner or at the pace that we all hoped it would be. Problems highlighted by the then Secretary of State for Health, Rt Hon Alan Milburn MP, in the foreword of the NSF remained: ‘Services sometimes fail to meet older people’s needs...by allowing organisational structures to become a barrier to proper assessment of need and access to care, and because the best evidence-based practice is not in place across important clinical areas.’

The NSF sets out a programme of action and reform to address these problems. However, there are reports that services are not being developed because NICE guidance has not been published and that patients are not identified and treated because those structures have not been established. We also hear reports about patients who present in hospital with a fracture who are not investigated for osteoporosis, because organisational structures still do not prompt staff to do so. Finally, even amongst those fracture patients who are lucky enough to receive preventive treatment for osteoporosis during their hospital stay, a significant portion do not continue to be treated because the patient’s GP is not informed about the diagnosis. These indications that services are not being developed and integrated as we might hope led to the production of this report.

The NSF promised to ‘modernise NHS and social services and promote new ways of working’. For osteoporosis, we are still some way off this goal. However, we are confident that this can be achieved: an increased focus from Government and the NHS can establish the services detailed in the NSF. We hope that this report will help to deliver the full potential of the NSF so that patients with, or at risk of, osteoporosis can finally gain access to the services that they deserve.

John Austin MP
APPOG Co-Chair

Baroness Cumberlege CBE DL
APPOG Co-Chair
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Executive Summary

1. Despite affecting 1 in 2 women and 1 in 5 men over the age of 50 and causing 180,000 osteoporotic fractures at an annual cost exceeding £1.7 billion (UK), osteoporosis has frequently been overlooked by health policy-makers and the NHS.

2. The National Service Framework (NSF) for Older People marked an important shift in osteoporosis policy. The positioning of osteoporosis within this high priority Government health policy document provided hope for real change and signalled the recognition of the seriousness of the condition and its effects.

3. The NSF provides the commitment and the vehicle to develop integrated falls and osteoporosis services. The guidance being produced by the National Institute for Clinical Excellence (NICE) in this area is intended to build upon and improve the services that the NSF should already be establishing. If the broad framework of services described within the NSF is not implemented in time or appropriately, there is a danger that the opportunities provided by NICE might also be wasted.

4. The Government has stated that the service standards within the NSF must be put in place by April 2005, namely that all health and social care systems should have established an ‘integrated falls service’. The Government expected Primary Care Trusts (PCTs) to demonstrate their progress in planning these services in April 2004.

5. On the evidence assessed for this report, there is a strong concern that the NHS will not achieve the NSF’s April 2005 target. The initial focus for many local health and social care organisations has been the development of initiatives to prevent falls, however, these efforts have not been reflected in the development of integrated osteoporosis services. As the NSF recognises, services must be designed to ensure that the impact, as well as the number, of falls is reduced. Integrated osteoporosis services are the necessary component for delivering this.

6. One of the key blocks to implementation is the lack of priority afforded to osteoporosis by Government and PCTs. Although the inclusion of osteoporosis within the NSF should be a clear indication of priority, it appears that the subsequent lack of endorsement for osteoporosis from Government and the exclusion of the condition from the General Medical Services (GMS) contract have undermined the position of osteoporosis within the NHS. The All Party Parliamentary Osteoporosis Group (APPOG) urges the Government to consider the inclusion of osteoporosis within the Quality and Outcomes Framework of the GMS contract at the earliest opportunity.
7. Despite NHS devolution, APPOG believes that the Government has a key role to play in ensuring the development of high standard and consistent integrated falls and osteoporosis services across the country. This can be achieved by providing leadership and assistance to local health and social care services. Many PCTs are still unclear about what an ‘integrated falls service’ is and what is expected of them under Standard Six of the NSF. Government must play a leading role in solving these problems.

8. Implementation of the NSF does not need to be difficult. APPOG supports the full and timely implementation of the NSF and has made a number of recommendations directed at the NHS and Government to assist in achieving this aim. These are practical and are often inexpensive. For example, we recommend that each PCT choose a named individual within the PCT to spearhead services. The report has also developed an algorithm (Diagram 1) included on page 22 to help de-mystify services.
Section 1: Background

1.1 Osteoporosis is known as the ‘silent disease’ because it often remains undetected until after a fracture has been sustained. ‘Silent disease’ is also a fitting description of the way in which it has been frequently overlooked by health policy-makers and by the NHS. Recently however, growing concerns about the public health impact of the condition, alongside spiralling costs and a strengthening patient voice, have led to an increased level of awareness and an improved policy focus.

1.2 Despite the development of policy, and in particular Standard Six of the National Service Framework for Older People (NSF), it has become apparent that change is not occurring at the pace – or in the manner – desired. Since the publication of the NSF in March 2001, reports from constituents, clinicians and the National Osteoporosis Society (NOS) have indicated that implementation has been patchy.

1.3 The Government has clearly stated that the NSF service standards must be put into place by April 2005. However, concerns that this requirement was not going to be achieved prompted APPOG to look more closely at the progress of implementation. Our starting point was to examine whether the interim (2004) target had been accomplished, namely that all Local Delivery Plans (LDPs) should include the development of an integrated falls and osteoporosis service. It quickly became apparent that this target appeared not to have been achieved and also, therefore, that the Minister’s assertion that ‘All [Strategic Health Authorities] SHAs currently report that the April 2005 target will be achieved in their area’ seemed implausible.

1.4 This report examines whether osteoporosis services are being established at the local level in line with the NSF, and if not, why not. It also looks at the support that might be needed to assist the NHS to achieve the April 2005 target.

1.5 Our inquiry included an audit of Local Delivery Plans (LDPs) and Health Improvement Plans (HlMPs); a survey of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs); a fact-finding visit to Hungary and an audit of other relevant evidence.

‘Silent disease’ is also a fitting description of the way in which osteoporosis has been frequently overlooked by health policy-makers and by the NHS.
Section 2: Osteoporosis, policy and the EU context

2.1 Health and financial impact of osteoporosis

2.1.1 Osteoporosis literally means ‘porous bones’. It occurs when the honeycomb structure inside bone becomes thinner, making it fragile and liable to break easily. Osteoporosis usually affects the whole skeleton but it most commonly causes fractures of the wrist, spine and hip. Osteoporosis itself is asymptomatic but the resulting fractures (termed ‘osteoporotic fractures’) have a substantial impact on patients. Hip and spine fractures, in particular, can lead to severely reduced quality of life and morbidity burden and, in a significant number of cases, to premature mortality.

2.1.2 It is estimated that there are about 2.7 million women living with osteoporosis in England. Previous estimates suggested that 1 in 3 women and 1 in 12 men over the age of 50 experienced an osteoporotic fracture, but new evidence shows that osteoporotic fractures occur in 1 in 2 women and 1 in 5 men over 50.³

2.1.3 NICE has reported that the number of osteoporotic fractures (including recurrent fractures) in women alone, is at least 180,000 in England and Wales annually⁴. Of these fractures, 70,000 are hip fractures, 41,000 are wrist fractures and 25,000 are vertebral fractures. The number of vertebral fractures is believed to be grossly under-reported, with as many as 70% failing to come to clinical attention.

2.1.4 Vertebral fractures can cause back pain, loss of height and curvature of the spine (kyphosis or ‘dowager’s hump’) and are common in younger post-menopausal women as well as older women. These effects can cause problems with breathing, eating, digestion and dressing. Vertebral fractures are often triggered by everyday activities such as bending or lifting and tend to lead to another fracture. They can be painless (‘silent’) or cause severe pain at the time that a fracture occurs, usually only resolving after six to eight weeks. Multiple spinal fractures often cause long-term effects on quality of life and give rise to an increased risk of mortality.

2.1.5 Hip fractures mostly affect frail, older (75 years plus) women and often hasten death in this group because of immobilisation; risks associated with surgery and co-existing health problems. Hip fracture frequently leads to a loss of independence and many patients subsequently require residential or nursing care. The psychological impact of this can be devastating for a woman: a survey suggested that 80% of older women would rather be dead than experience the loss of independence and quality of life that results from a bad hip fracture and subsequent admission to a nursing home⁵. The financial costs of osteoporotic hip fractures are high, with an average cost per hip fracture of £13,000 in the first year and £7,000 for the subsequent year⁶.
2.1.6 The combined social care and hospital costs for treating the 86,000 hip fractures that occur annually in men and women in the UK amount to over £1.7 billion. This figure is expected to increase to an estimated £2.1 billion by 2010. The financial costs for all types of osteoporotic fracture are greater, but no reliable estimate is currently available.

2.2 Osteoporosis policy

2.2.1 The first significant pieces of osteoporosis policy in the UK, the 1994 Advisory Group on Osteoporosis (AGO) Report followed by the 1998 Osteoporosis Strategy, were an important development and denoted the arrival of osteoporosis onto the healthcare agenda. There was a growth in recognition that osteoporosis was largely preventable and treatable and that active preventive work would save more than it cost. However, although the documents were useful for raising general awareness of osteoporosis, they did not effect any major change in the way services were organised; neither did they impact significantly on the patient experience.

2.2.2 In 2001, the AGO Report and Osteoporosis Strategy were superseded by the NSF for Older People. Standard Six of the NSF set out a standard of care for older people at high risk of falling and recognised that the detection, assessment and care of people with, or at high risk of, osteoporosis was integral to this Standard.

2.2.3 The NSF provided a new approach to establishing falls and osteoporosis services and the mandatory status of the policy provided hope for real change. A key feature of the NSF was the recommendation that integrated services should be developed. Osteoporosis had traditionally been tackled in a disjointed fashion, with little by way of connection between primary and secondary care. Patients who had fractured were not always investigated for osteoporosis, with the result that many left care without any treatment for osteoporosis at all.

2.2.4 The NSF, which comprises a 10-year framework running from 2001 to 2011, sets out milestones that are designed to ensure that integrated falls and osteoporosis services are developed in a timely manner. The final osteoporosis milestone is due to be achieved in April 2005 [See Box 1].

The NSF for Older People provides a national framework of standards for older people with, or at risk of, osteoporosis. Implementation of the NSF is mandatory for the life of the 10-year programme.

April 2003 – Local healthcare providers (health, social services and the independent sector) should have audited their procedures and put in place risk management procedures to reduce the risk of older people falling.

April 2004 – The Health Improvement Plan (HImP), and other relevant local plans developed with local authority and independent sector partners, should include the development of an integrated falls service.

April 2005 – All local health and social care systems should have established this service.
2.2.5 Since the launch of the NSF, the Government has instructed NICE to develop guidance in the areas of osteoporosis and falls [See Box 2]. This guidance will take the form of technology appraisals of treatments for osteoporosis and clinical guidelines setting out a ‘gold standard’ for management of osteoporosis and falls. These are designed to build upon and improve the framework of services set out in the NSF. One such area of improvement is that whereas the key focus of the NSF standard is on preventing hip fracture, NICE guidance will ensure that all types of osteoporotic fracture are addressed.

Box 2

NICE is currently developing clinical guidelines on:

- Falls – due to be published November 2004
- Osteoporosis – due to be published February 2006

And technology appraisals on:

- The use of newer treatments in the primary prevention of osteoporosis in post-menopausal women – due to be published in September 2005
- The use of newer treatments in the secondary prevention of osteoporosis in post-menopausal women – publication expected in January 2005, subject to appeal process
- The effectiveness of faller’s clinics – due to be published October 2005
- Strontium ranelate for osteoporosis – due to be published January 2006

2.3 EU context

‘Osteoporosis is a huge problem in Europe. The most important thing is that this suffering and debilitation can be prevented. We have to work on this together. It’s time for action.’

Elly Plooij-van Gorsel, MEP, The Netherlands

2.3.1 In 1998, the European Commission published a report on Osteoporosis in the European Community – Action for Prevention. The Commission recognised that the number of osteoporotic fractures and their costs were predicted at least to double in the next 50 years unless effective preventive strategies were developed now. The Action Plan aimed to raise the priority of osteoporosis at government level in each of the Member States, with particular emphasis on the development of effective strategies for the prevention of osteoporotic fractures in high-risk individuals.

2.3.2 The EU Osteoporosis Consultation Panel was then set up to implement the Plan, and the Panel published its report ‘Osteoporosis in the European Union: Member States policy progress report’, in February 2004. The report suggested that the public, healthcare professionals and policymakers in Europe were starting to work together to reduce the suffering and unnecessary costs caused by osteoporotic fractures. However, there was concern that a great deal remained to be achieved.
Hungary: a case study

Although one of the less affluent EU member states, Hungary appeared to have a high standard of osteoporosis care. In June 2004, APPOG, together with the UK’s National Osteoporosis Society, visited Budapest to investigate Hungary’s progress further.

In the early 1990s the prevalence of osteoporosis in Hungary was established as being far greater than the European average. In 1995 the Hungarian National Osteoporosis Programme was launched with commitment from the Hungarian Society for Osteoporosis & Osteoarthrology and the Ministry of Health, Social & Family Affairs.

The UK delegation found that osteoporosis services across Hungary appeared to be highly standardised with little or no geographical variation. For a country about a third of the size of the UK with a population roughly approximating Greater London, the service was provided through a robust network of 100 local, 11 regional and one national specialist osteoporosis centre. About 800 specialist clinicians, regulated by the professional society, offer services including risk assessment, bone density scanning and treatment according to national guidelines. The uniformity was strengthened by shared IT, training and quality assurance systems.

The number of reported hip fractures in Hungary stood at 16,840 in 1995 (the year the service was implemented), increasing to 20,040 in 1998. Between 1998 and 2001 numbers peaked at 20,200 in 2000 and dropped slightly to 20,010 in 2001. The Hungarian Ministry of Health, Social & Family Affairs has claimed that the programme has ‘stopped the predicted rise of osteoporotic fractures’ and that the ‘fracture data demonstrates that the Programme is successfully starting to slow down hip fracture rates’.

Hungary has achieved remarkable progress towards a high quality, standardised, national osteoporosis service for its population. The UK delegation felt that the emphasis on provision of local services was a model that the UK might consider emulating.
Section 3: Current state of integrated falls and osteoporosis services – measuring up to the targets

3.1 Background

3.1.1 This report is based upon four strands of research carried out by APPOG and the National Osteoporosis Society (NOS) in evaluating progress of NHS organisations in England towards meeting the April 2004 and April 2005 NSF milestones.

3.1.2 The four strands were:
   i. NOS conference – focus groups of PCT staff evaluated the development of integrated falls and osteoporosis services (Oct 2003)
   ii. APPOG audit of LDPs from NHS organisations (Jan – Sep 2004)
   iii. NOS survey – assessed bone densitometry provision (June – Oct 2004)

3.2 NSF April 2004 milestone – how did the NHS perform?

April 2004 – The Health Improvement Plan (HiMP), and other relevant local plans developed with local authority and independent sector partners, should include the development of an integrated falls service

3.2.1 The APPOG audit of local plans (266 plans obtained) found that:
   - 16% (43) PCTs did not contain a reference either to osteoporosis or falls
   - 76% (202) PCTs made no reference to osteoporosis
   - 17% (46) made no reference to falls
   - only 23% (62) made reference to falls and osteoporosis

3.2.2 The small proportion (23%) of PCTs making reference to both osteoporosis and falls in their plans was very disappointing and offers some indication that the April 2004 milestone had not been met.

3.2.3 A far greater number of PCTs made some reference to falls services rather than osteoporosis services. Of those PCTs that made at least one reference to osteoporosis in their LDP, all but two also made reference to falls services. This illustrated two points, firstly that better progress had been made with planning the falls, rather than osteoporosis, components of Standard Six and, second, that there was a lack of understanding about the role of osteoporosis in developing an integrated falls service. Some PCTs appeared not even to be aware of the requirement for osteoporosis in an ‘integrated falls service’ as outlined in Standard Six.

3.2.4 The SHA Local Delivery Plans appeared to confirm the PCT findings that the April 2004 milestone was not achieved – only one third of their Plans included an appropriate reference to integrated falls and osteoporosis services.
3.3 NSF April 2005 milestone – what are we expecting?

**April 2005** – All local health and social care systems should have established this service.

3.3.1 The APPOG Survey asked a sample of PCTs whether they would meet the April 2005 milestone and of the respondents:
- **43% (21)** stated they were likely to meet the April 2005 target
- **16% (8)** stated they were unlikely to meet the April 2005 target
- **41% (20)** did not respond to the question clearly enough to determine the answer

3.3.2 Less than half of the PCTs expected that they would meet the April 2005 milestone. This is again very disappointing, although it represents an unexpected improvement on the success rate for the April 2004 milestone, should their expectations be met. The finding that at least 1 in 8 (16%) PCTs admit to being unlikely to meet the milestone is of serious concern.

3.3.3 Information gathered from the SHAs suggested that:
- **32% (9)** SHAs were likely to meet April 2005 milestone
- **29% (8)** SHAs were not likely to meet April 2005 milestone
- **39% (11)** not possible to tell (and so probably unlikely)

When collated with the PCT findings, these suggest that there are pockets of progress around the country, however service implementation is, at best, patchy.

3.3.4 The findings suggest that the majority of local NHS organisations have not met the April 2004 milestone and that a significant proportion also seem likely to miss the April 2005 milestone. This has a serious implication for patient care and does not bode well for the implementation of ‘gold standard’ NICE guidance on osteoporosis, which will be disseminated within the next two years.

3.3.5 The prior suspicion that PCTs lacked understanding about the definition of an ‘integrated falls service’ as set out in the NSF Standard Six was reflected in the survey responses. One PCT Director of Public Health stated ‘I am not sure what a fully integrated service is.’ Although this sort of honesty was welcomed, it was alarming to hear such a statement so far into the NSF programme and so close to the 2005 milestone. Other gaps in understanding were less explicit, with a number of PCTs ignoring osteoporosis whilst putting their efforts into developing falls services.

3.3.6 The survey responses and the audit have shown that the initial focus for many PCTs has been the development of initiatives to prevent falls; however, these efforts have not been reflected in the development of integrated falls and osteoporosis services. As the NSF recognises, services must be designed to ensure that the impact, as well as the number, of falls is reduced. Therefore, we now need to see a sustained effort to establish fully integrated services with a strong emphasis on the prevention and treatment of osteoporotic fracture. In this way we will ensure that the NSF achieves its full potential and the NHS provides the service that patients need.
**DXA Scanning**

An indirect method of evaluating progress with integrated falls and osteoporosis services is to look at the provision of diagnostic tools for people at high risk of osteoporosis. Osteoporosis is diagnosed using hip or spine dual energy x-ray absorptiometry (axial DXA), which scans the hip or spine to measure bone mineral density.

The NOS estimates that the number of bone density scans required, as part of a selective case finding approach, to meet the needs of people at high risk of fracture is 1,000 DXA scans per 100,000 population. The NOS is carrying out a survey to assess whether current DXA provision in England is sufficient to satisfy current need.

Preliminary findings suggest that in the UK the average waiting time between referral and DXA scan is 18 weeks (range of 1 to 78 weeks). This compares poorly with Hungary, where the waiting time was between two to three weeks. The waiting time is significant as, after a vertebral fracture for example, the risk of a second fracture is highest within the first 12 weeks.

The average weekly use of DXA in each centre is 26 hours per week (range 3 to 50 hours), suggesting that there is capacity for extending these hours to improve waiting times.

Although the NOS is still collecting and analysing these data, preliminary results clearly indicate that the waiting times in some parts of the country are at an unacceptable level. This is likely to be due to: a) geographical location of DXA scanners; b) variation in provision of qualified staff (such as radiographers) to operate the scanners; c) scanners being purchased with no, or inadequate, running costs, causing scanners to be operated for only a few sessions per week.

As osteoporosis services become more widespread, new evidence or guidance emerges (eg NICE guidelines) and the population continues to age, demand for DXA scanning may increase.

...waiting times for a DXA scan in some parts of the country are at an unacceptable level...
Section 4: Blocks to implementation of integrated falls and osteoporosis services

4.1 What the NHS says

As part of our survey, we asked service developers what they felt were the greatest blocks to implementing integrated falls and osteoporosis services. All of the responses contained one or more of the concerns below.

4.1.1 Lack of Government/PCT priority

A number of PCTs spoke of the lack of priority afforded to integrated falls and osteoporosis services by Government. The responses revealed that PCTs do not consider the implementation of the National Service Frameworks as a priority, despite being mandatory. The lack of priority accorded to osteoporosis was undermined by its exclusion from the new General Medical Services (GMS) contract. The contract is now a major stumbling block for developing osteoporosis services in primary care.

‘Osteoporosis is not identified as a government priority. GMS 2 quality outcome indicators are currently a higher priority on the GP agenda’

4.1.2 Funding

Over half of the PCTs believed that a lack of funding, especially for prescribing and DXA scans, was the main block to implementation. Many PCTs were experiencing difficulty in obtaining initial funding:

‘The main difficulty within the PCT in respect of these services is identifying sufficient funding for the DXA service.’

‘There are the usual pressures of competing demands on limited funding.’

‘Difficulties have been encountered around funding generally.’

Some PCTs made reference to the fact that they had only been able to allocate one-off funding for a pilot service or they were aware that current funding would not stretch to meet the implementation of integrated falls and osteoporosis services. PCTs have commonly used initial pump-priming funds from the commercial or voluntary sector to fund components of the service, eg an Osteoporosis Nurse Specialist post or a DXA scanner, but subsequently encountered difficulties in securing PCT funding for the long-term:

‘Resources have been identified within the Local Delivery Plan to support the continued development of the service; however, given current pressures facing the health community, this investment has been deferred.’
4.1.3 **NICE slippage**

PCTs referred to the delay in the issuing of NICE guidance as a reason why they have deferred the implementation of services and the development of a strategy.

‘... waiting for NICE guidelines before completing the osteoporosis strategy.’

4.1.4 **Multi-agency working**

Multi-agency working (or partnership) also often proved to be a sticking point.

‘The principal challenge in moving towards full integration between services for osteoporosis and falls has been to coordinate the numerous strands of work between, and indeed within, partner agencies in the health economy.’

Integrated falls and osteoporosis services span primary care, secondary care, social and community care and work effectively when a number of stakeholders are included in the planning and implementation processes. Multi-agency working is still in its early stages within the ‘local health economies’ and, therefore, moving towards joint working has led to difficulties.

4.1.5 **Staff recruitment**

A number of PCTs cited staff recruitment as a major block.

‘Difficulties include the recruitment of staff to use the DXA and provide the service, including administration staff for the reporting of scan information and forwarding to the GP.’

‘...The GMS contract is now a major stumbling block for developing osteoporosis services in primary care.’
One year ago...

In October 2003 focus groups, each comprising a different professional group, were asked to identify the blocks to implementing falls and osteoporosis services and to rank them. The following table shows the top three blocks as ranked by the groups:

<table>
<thead>
<tr>
<th>In rank order</th>
<th>Nurses &amp; PAMs*</th>
<th>Commissioners &amp; prescribers</th>
<th>GPs</th>
<th>Public health &amp; social care</th>
<th>Falls leads</th>
<th>All groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstacle 1</td>
<td>Lack of dedicated leadership</td>
<td>Competing priorities</td>
<td>Lack of resources</td>
<td>Competing priorities</td>
<td>Communication (and attitudes)</td>
<td>Competing priorities</td>
</tr>
<tr>
<td>Obstacle 2</td>
<td>Lack of commitment at senior level</td>
<td>IT development mismatch</td>
<td>IT development mismatch</td>
<td>Lack of commitment at senior level</td>
<td>Capacity vs. demand</td>
<td>Lack of commitment at senior level</td>
</tr>
<tr>
<td>Obstacle 3</td>
<td>Lack of training &amp; education</td>
<td>Lack of resources</td>
<td>Lack of training &amp; education</td>
<td>Absence of osteoporosis &amp; falls in GMS contract</td>
<td>Lack of resources</td>
<td>Lack of resources</td>
</tr>
</tbody>
</table>

*PAMS = Professionals Allied to Medicine

The most highly ranked obstacles were competing priorities, lack of commitment at senior level and lack of resources. The pressures that PCTs are under to fulfil requirements over the broad clinical and managerial spectra are well understood, but it seems that this barrier, as well as ‘lack of commitment’, have both declined in importance over the last year as they were rarely quoted in the recent survey responses. The third obstacle was lack of resources, which has grown in importance and is now quoted as the single largest block to implementation.
4.2 What APPOG says

4.2.1 Lack of understanding

Our research showed that many NHS organisations lacked understanding about the definition of an ‘integrated falls service’, with many not even realising that osteoporosis services were a vital part. It further showed that some of the NHS organisations were confused about their role, for instance, one SHA told us that it did not collect information about PCT progress on this mandatory requirement. This contradicts the role of SHAs as laid out by Dr Stephen Ladyman:

‘Strategic Health Authorities are the key link between the Department and the National Health Service. They ensure that national priorities, such as the development of falls services, are integrated into plans for the local health service. Their role is to ensure coherency and developing strategies for the local health service, ensure high quality performance of the local health service and its organisations, working towards improved performance, and to building capacity in the local health service.’

4.2.2 Lack of priority

Our research shows that integrated falls and osteoporosis services have not been prioritised in the NHS. Implementation of osteoporosis services fared poorly compared with implementation of falls services, other Standards contained within the NSF and generally with other clinical areas across the board. Until the issue of implementing the services set out in the NSF becomes a high priority we cannot envisage that the full implementation of long-term, sustained integrated services will be achieved. Furthermore, if PCTs are unable to implement a mandatory policy appropriately, this raises serious concerns about the current ability of the NHS to implement NICE guidance in this area.

4.2.3 Poor strategic approach

Our research shows that only about 40% of PCTs have strategies for implementation of osteoporosis services. APPOG is concerned that this lack of strategic approach will lead to services being developed in a short-sighted manner, if at all.

4.2.4 Leadership

One year ago named leads for implementation of Standard Six of the NSF were few and far between. Since then the NHS has made good progress and it now appears that about 85% of PCTs have a named lead for this work. However, APPOG is uneasy that the remaining 15% of PCTs, that do not yet have a named lead, seemingly cannot hope to achieve implementation of services by April 2005.
Section 5: Recommendations

5.1 What the Government needs to do

Although the Government has aimed to devolve responsibility for services to the front line, APPOG believes that the Government still has a central role to play in ensuring the development of high standard and consistent integrated falls and osteoporosis services across the country.

5.1.1 Include Osteoporosis in the GMS Contract

It is now clear that the exclusion of osteoporosis from the Quality and Outcomes Framework of the GMS contract has had a negative impact on the implementation of the osteoporosis components of the NSF at a local level. Standard Six of the NSF clearly states that identifying patients at risk of osteoporosis ‘should be a priority for primary care’.

Osteoporosis is an excellent candidate for inclusion within the GMS contract: many of the risk factors already included in the contract relate to osteoporosis. Conducting a risk assessment to identify those at risk of fracture is relatively quick and simple and could result both in a reduction of fractures and considerable financial savings. Furthermore, inclusion would assist in achieving the aims of the NSF in encouraging better detection of osteoporosis prior to fracture and confirm osteoporosis in the minds of professionals and service providers as a primary care priority.

5.1.2 Provide Leadership

Government should act to ensure that PCTs and SHAs are fully aware of what is expected of them. No SHA in the country should be able to claim that it does not fully understand its responsibility for monitoring and for providing strategic support for the PCTs in its area.

Leadership is also necessary for sharing best practice and helping local services to interpret national policy. The Government must take responsibility for ensuring that its policies are fulfilled by tracking their implementation and communicating clearly with the NHS.

It is clear that there is a general lack of awareness and understanding about what the NSF’s fully integrated falls and osteoporosis service should look like. Although some of the finer points of the service are indeed currently being developed by NICE, this should be no excuse for the non-implementation of the framework of services outlined in the NSF, it being a stand-alone document. Although some implementation assistance has been offered to local services, it would be helpful if this could be made plainer and more accessible; it is apparent that some PCTs are still unaware of the existence of this assistance. Better communication between the centre and local services about what assistance is available would help PCTs understand exactly what is expected of them when implementing the NSF or any other national policy.
5.2 What the NHS needs to do

5.2.1 Don’t wait for NICE >> Implement the NSF

The delay in issue of NICE guidance for managing and treating osteoporosis (notably the technology appraisals and osteoporosis clinical guideline) should not hinder the full and timely implementation of Standard Six of the NSF. This point is particularly worthy of note, since the NSF was conceived and published prior to the relevant referrals to NICE. The services described within Standard Six can be developed on a stand-alone basis, the framework of which can be strengthened and developed by the ongoing work of NICE.

5.2.2 Osteoporosis >> Ignore it at your peril

Many local health organisations have focussed their efforts on falls prevention. Although this is useful in helping to prevent fracture, it provides only part of the answer. No matter how effective a falls prevention programme, people will inevitably still fall and fracture. Furthermore, osteoporotic vertebral and wrist fractures do not normally occur as a result of a fall, but from people engaging in everyday tasks such as dressing themselves.

We must work towards ensuring that people have healthy bones and that those at risk of fracture are identified and given lifestyle advice and treatment. If we are serious about preventing osteoporotic fracture, a single pronged approach that only utilises the falls prevention programme will not achieve this alone. Such services must be truly integrated so that there is also a strong emphasis on osteoporosis.

5.2.3 Funding >> Be innovative

PCTs are often nervous about the funding needed for DXA provision and prescribing costs. Now that local health economies are bringing together health and social care decision-makers, the long-term savings in hospital stays and social care can be balanced against the initial outgoings needed to start preventing osteoporotic fractures in older people.

The impact of the initial outgoings can be minimised. Examples include using medicines management to reduce unnecessary expenditure on polypharmacy, negotiating fairly priced DXA scans with providers (including those in primary care) and being innovative, for example drawing upon nurse specialists and allied health professionals rather than doctors.

A small number of PCTs have reported that although funding was a problem initially, this resolved itself once the service was implemented and proved its worth.

5.2.4 Leadership >> Name the lead

Good progress has been made by over 80% of PCTs in identifying named leads responsible for taking implementation of services forward. However APPOG recommends that the remaining PCTs without a named lead make this a matter of priority. Having a named lead is a great motivator because it means that a named individual ‘owns’ and has responsibility for the service. This person must work across primary, secondary and social care.
5.2.5 Gather the evidence >> Make your case

A sound business case is a vital element in planning and implementing integrated falls and osteoporosis services. Information on epidemiology, clinical effectiveness, local demography, current and planned provision with economic data are all needed. A number of PCTs have put time and effort into making their case – getting copies of these cases will help other PCTs to construct theirs.

Senior level commitment, or ‘buy-in’, from the PCT Professional Executive Committee or Board is essential in paving the way to long-term, sustained service provision. Sadly, all too often, we have seen enthusiastic individuals fully developing a service only for it later to be ‘rationalised’ by the PCT. This can be prevented by gaining buy-in from senior PCT decision-makers in the planning phase.

5.2.6 Multi-agency working >> Take up the challenge

Integrated falls and osteoporosis services, by their very nature, require planning and implementation across many agencies and sectors. Multi-agency working is being encouraged as the model for local health economies so PCTs should aim to build on past successes. The implementation team could talk to others in the PCT if they are leading the way with joint working. A number of PCTs have reported that after initial ‘teething problems’, perseverance has led them to better-planned and effectively implemented services.

5.2.7 Primary care >> Use your key players

There exists in primary care a largely untapped potential for providing the key components of integrated falls and osteoporosis services. Provision through primary care ensures that services are accessible to a wider number of people, at a local level, and that delivery is assured in a more cost-efficient way.

5.2.8 Skilled workforce >> Develop your staff

There are various ways of overcoming skills gaps. Nurses and other allied health professionals can take on many of the key aspects of delivering osteoporosis services where it has historically been the domain of the medical professional. Nurse prescribing, for example, can open up prescribing of osteoporosis treatments. Another skills gap that has been reported is with staff trained in bone densitometry for DXA units. Developing existing staff to take on this role is eminently possible. The National Osteoporosis Society (NOS), for example, runs a training scheme for radiographers, technologists, clinical scientists and other health care professionals to operate bone densitometry equipment.
5.2.9 **DXA provision**

We recommend that local health organisations fund the efficient and effective running of DXA services and endeavour to ensure the location of these facilities are more evenly distributed. Despite being a cheaper alternative to hip or spine (axial) DXA scanners, the purchase of peripheral DXA scanners (ie those that measure bone density in the forearm or heel) is not recommended. One solution would be to increase the number of mobile axial DXA units, which have the potential of offering the PCT a highly cost-effective way to deliver diagnosis.

5.2.10 **Demystifying integrated osteoporosis services**

Models of delivery for integrated falls and osteoporosis services have in the past tended to be unclear to the point of mystifying for some health professionals. The following diagram aims to set out the bare bones of the requirements of an osteoporosis service that can be slotted into an integrated falls and osteoporosis service.

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“...falls prevention...provides only part of the answer...osteoporotic vertebral fractures do not normally occur as a result of a fall, but from people engaging in everyday tasks such as dressing themselves.”
Diagram 1

Requirements of an osteoporosis service

Primary/secondary/community care
- Medical professional
- Nurse
- Allied Health Professional

Risk recognised
- Computer search
- Face/face consultation
- Self referral
- Patient presents with fracture

Primary/secondary care
- Medical professional
- Nurse
- Allied Health Professional

Risk assessed
- Using a validated tool, e.g., Black et al. for 65+ years
- Postal questionnaire
- Face/face consultation

Primary/secondary care
- Medical professional
- Nurse
- Allied Health Professional

Bone density scanning
- Axial DXA to diagnose osteoporosis
- Peripheral DXA to exclude low risk patients*

Primary/secondary care
- Medical professional
- Nurse
- Allied Health Professional

Low risk
- Lifestyle advice (diet, exercise, etc)
- Information

Medium risk
- Lifestyle advice
- Information
- Treat to RCP guideline†
- Monitor

High risk
- Lifestyle advice
- Information
- Treat to NICE guidance
- Monitor
- Refer to other services

* If already in existence – purchase of new peripheral DXA not advised at this stage
† until NICE guidance on primary prevention issued

Falling short: Delivering Integrated Falls and Osteoporosis Services in England
References


2. House of Commons Written Answer. Falls and osteoporosis services. *Hansard* 1 July 2004; Col 408W


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