++SCHEDULE 2 – THE SERVICES

A. Service Specifications

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Service Specification No.	
Service	Fragility Fracture Secondary Prevention Service
Commissioner Lead	Oxfordshire Clinical Commissioning Group
Provider Lead	Oxford University Hospitals Trust
Period	1st April 2014
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

An estimated three million people in the UK have osteoporosis. These people have a major increased risk of bone fractures, with combined health and social costs for hip fracture alone of £2.3 billion per year. There is a significant association with long-term morbidity and mortality with 50% of individuals with hip fracture unable to live independently and 20% dying within 6 months. A significant number of acute hospital, community rehabilitation and nursing home admissions are attributed to fragility fractures with hip fractures making up 54% of the total health and social care costs from fragility fractures.

Prevention of a second fracture after the first fracture improves quality of life and reduces health and social care costs. Current national guidance provides evidence that effective case finding and effective oral treatments will reduce the risk of future clinical fracture by up to 50% and these reductions in fracture incidents are realised after three years of pharmacotherapy.

A Fragility Fracture Secondary Prevention Service (FSPS) is therefore a critical component of an effective integrated pathway for the management of Fragility Fracture and is supported by national policy and guidelines:

- British Orthopaedic Association (2007) The care of patients with fragility fractures – The Blue Book.
- Department of Health (2009) Fracture prevention service: An economic evaluation.
- Department of Health (2009) Falls and Fractures: effective interventions in health and social care.
- NICE (2008) TA 160, TA161 and TA204.
- Northern Ireland fragility fracture working group (2009) The prevention and management of fragility fractures in Northern Ireland.
- The Management of Hip Fracture NICE June 2011.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

1. To increase the percentage of patients receiving bone health and falls assessment (questionnaire, bloods, DXA).
2. To achieve a reduction in the recurrent fracture rate from 12% to 9% within 2 years.
3. To deliver financial savings in the medium (3-5 years), across the health and social care services in Oxfordshire, measured by a reduction in re-admissions arising from recurrent fracture and falls.

3. Scope

3.1 Aims and objectives of service

Aim

To respond to the first fracture with effective management in order to prevent a subsequent fracture and so reduce associated morbidity and mortality.

Objectives

1. To assess and manage the bone and falls risk of all patients over 50 who have suffered a fragility fracture (excluding fingers, scaphoid, toes, face and skull) to prevent subsequent fractures.
2. To improve the quality of the experience for the individual and their family by developing equality of access to information and management of all fragility fractures.
3. To deliver best practice in the care of people who have fragility fracture and work in an integrated way with other services along the Fragility Fracture pathway.

3.2 Service description/care pathway

The FSPS provided by Oxford University Hospitals Trust (OUHT) is a key component of the Integrated Fragility Fracture Pathway for Oxfordshire and is required to deliver specialist secondary fracture prevention assessment and management to patients and to support an integrated approach for fragility fracture in Oxfordshire.

The service will deliver:

1. Triage, assessment and treatment plans by specialist nurses/therapists in trauma clinics/community clinics which have two primary outputs:
    a. Diagnosis of osteoporosis, medication for bone strengthening to halt or reverse the bone changes that lead to osteoporosis and fragility fracture, compliance to remain on medication.
    b. Diagnosis of the modifiable faller and a falls prevention plan.
2. Long-term management, monitoring and treatment compliance support for in the community.
3. Expert patient support developed and delivered in partnership with the voluntary sector.
4. Specialist expertise to support the multi-disciplinary in-patient trauma team at the John Radcliffe, Horton Hospitals and community rehabilitation units to:
    a. ensure secondary prevention is carried out in line with best practice
    b. that the assessment and management plans for those aged 75 and over are consistent across the county.
    c. ensure that the pathway for DEXA scans and follow-up triage and assessment is adhered to.
5. Specialist support for complex falls interventions delivered by community services.
6. Specialist support secondary care clinicians in managing complex and rare bone conditions.

Service Model

The service will be led by a Clinical specialist nurse / therapist with senior clinical supervision by a consultant in Bone Health. This consultant clinical leadership does not form part of the payments within this service specification, as it is already within their work specification.

All individuals will be seen by specialist fracture prevention practitioners (nurse or therapist).

Individuals aged between 50 to 75 years will receive a bone health and falls assessment and will be provided with an appointment for a bone density scan (DXA). Following the DXA scan the individual will be triaged by the specialist nurse and treatment plan put in place. Those individuals requiring further investigations will be referred to the interface clinic for individualized bone and falls treatment advice. The treatment plan will be sent to the individual's GP (see Appendix) diagram.

Individuals aged over 75 year of age will have a bone health and mini-falls assessment as part of the trauma episode (either on ward or clinic) and have a management plan put in place and given to the individual as well as sent to their GP.

Only if the assessments indicate an unusual history of bone health e.g. severe kidney disease or endocrine problems or complicated falls risks then they would be referred to specialist services. The majority of individuals will be managed in primary care by their GP's. – see flow chart and criteria below

Falls Assessment
All specialist falls prevention assessment and treatment management programmes for those with a complex presentation to be delivered on referral by the falls prevention service in community clinics across the county as present. Simple falls issues will be part of the secondary prevention assessment and management plan

Trauma Clinics

The service will be in every fracture out-patient clinic to deliver:

- for individuals under 75 years of age with suspected fragility fracture a short contact assessment to give information on the process, and make arrangements for a DEXA scan.
- for over 75 with suspected fragility fracture a combined bone health and falls assessment, development of an agreed management plan with personal information prescription and referral on for a full falls assessment if indicated or to consultant -led bone health clinic if criteria met.

The service will triage all DEXA results from fracture outpatient clinics and in-patient trauma wards for those individuals with suspected fragility fracture. The service will contact those with normal results to inform them and their GP of these and will also provide lifestyle advice for maintaining good bone health. For those with an abnormal result the service will provide a follow-up appointment in the community clinic.

Out-patients community clinics

The service will deliver out-patient community clinics for those under 75 with an abnormal result on DEXA, from referrals generated in fracture clinic or by in-patient trauma teams.

3.3 Population covered

Population:
Those individuals registered with an Oxfordshire Clinical Commissioning Group GP.

Patient group:
Those individuals with a fragility fracture which is defined as:

A fracture caused by falling from standing height or lower at walking speed or slower in a fracture site excluding face, skull, scaphoid, fingers and toes, in men and women of age ≥ 50years. It also includes vertebral fracture even if there is no history of trauma.

3.4 Any acceptance and exclusion criteria and thresholds

Referral Criteria:

a. Pre-menopausal women or men under the age of 60 years presenting with osteoporosis.
b. Inability to take or tolerate oral treatments for osteoporosis.
c. Osteoporosis due to complex medical diseases (breast/ prostate cancer, kidney disease, inflammatory bowel disease, cystic fibrosis etc.).
d. Acute painful vertebral fractures not improved after 6 weeks of physiotherapy.

Exclusion criteria:

a. No evidence of fragility fracture
b. Fragility fracture to figures, toes, scaphoid or head
c. Fracture due to high trauma or metastasis or other bone pathology.

3.5 Interdependence with other services/providers

There will be high level co-ordination between acute care, community care and primary care to support systematic and continuity of care delivery.

In particular, the FSPS will interface with -

- In-patient community rehabilitation service-managers and multi-disciplinary team.
- Community falls prevention service.
- In-patient staff and managers for Trauma at the acute hospital: John Radcliffe and Horton General.
- senior managers at OUHT and OHFT
- Patients and their families.
- Primary care-GPs and District Nurses
- Social and community services.
- Providers of Intermediate Care Beds in Oxfordshire.
- The voluntary sector e.g. the National Osteoporosis Society.

Relevant networks and screening programmes

Clinical leads will participate in the following national networks and audits:

- FRISCY clinical network- in order to develop and maintain best practice, share and develop new effective ways of delivering secondary prevention
- National Hip fracture database.
- Royal College of Physicians Falls and Bone Health Audit.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

1. NICE Quality Standards Hip fracture for adults QS16:

a. People with hip fracture are offered an assessment to identify their risk of falling in the future, and are offered help tailored to their circumstances to reduce these risks if needed.

b. People with hip fracture are offered an assessment of their risk of further fractures, and offered bone-strengthening drugs if the assessment suggests they are needed, before discharge from hospital.

2. NICE Guidance for Osteoporosis CG 146 2012.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

British Orthopaedic Association Standards for the Care of Patients with Fragility Fracture (2007):

1. All patients presenting with fragility fracture should be assessed to determine their need for antiresorptive therapy to prevent future osteoporotic fractures (Standard 5).
2. All patients presenting with a fragility fracture following a fall should be offered multidisciplinary assessment and intervention to prevent future falls (Standard 6).

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

Performance Indicator	*Threshold*	*Method of Measurement*	*Frequency*
% of individuals with a hip fracture who receive a falls and bone health assessment as an inpatient	Minimum 90%	Hip fracture data base RCP falls and bone health audit	Quarterly
The proportion of trauma inpatient fragility fracture patients receiving falls and bone health assessments	80% Minimum	Service Report	Quarterly
Proportion of individuals with a fragility fracture seen by fracture prevention services that are put on an individual management plan	90% Minimum	Service Report	Quarterly
Percentage of individuals maintained on bone medication at 1 year who have been seen by the service	Baseline to be established in Q1, 2014/15 and targets to be set at the beginning of Q2, 2014/15	Service Report	Quarterly
A reduction from 12% to 9% in the percentage of individuals who present with a fragility re-fracture within 2 years of first fracture by 2016	Two yearly	Service Report	2 yearly

6. Location of Provider Premises

The FSPS will be located at the Nuffield Orthopaedic Centre, OUHT. It will provide input to all out-patient fracture clinics at the John Radcliffe Hospital and the Horton Hospital, and will provide community clinics (minimum of 4, 1 per locality).

Patients are likely to be seen in a number of locations:

- Fracture clinics at the John Radcliffe Hospital
- Fracture clinics at the Horton Hospital
- Trauma Wards at the JR and Horton General Hospitals.
- Community clinics – at least one per Oxford health locality including at Abingdon, Bicester, Witney community hospitals.

Days/Hours of operation

The referral / administration hub will be open for telephone queries Monday–Friday in working hours.

7. Transfer of and Discharge from Care Obligations

All individuals will have a management plan that will be sent to the individual and their GP. The GP will then be responsible for putting the elements of the management plan related to prescribing and onward referral in place, and the continued monitoring of prescribing compliance.

All individuals at the end of their contact with the FSPS will have an information prescription to enable them to understand what they can do to manage their own condition and to prevent further fractures, including signposting to other services, groups and organisations.