

FINANCE COMMITTEE

DEMOGRAPHIC CHANGE AND AGEING POPULATION INQUIRY

SUBMISSION FROM NATIONAL OSTEOPOROSIS SOCIETY

What is your view of the effects of the demographic change and an ageing population on the sustainability of funding for (a) health and social care? What public services will individuals increasingly call on and in what way?

1. As the average age of the Scottish population rises, demand for NHS services among older people will also increase. Unless more is done to prevent long-term conditions which predominantly affect older people, the Scottish Government will need to commit more resources to treatment and care.

2. Men and women with osteoporosis have bones that are fragile and susceptible to fracture. These debilitating fractures are known as 'fragility fractures'. They are often the result of low-impact bumps or falls - incidents which would not result in fractures for people with healthy bones - and usually happen from a standing height or less. People with severe osteoporosis can suffer fractures while doing things as simple as turning over in bed. It is because of the impact that fragility fractures have on people that we seek to improve the way in which osteoporosis is prevented, diagnosed and treated.

3. Osteoporosis is a long-term condition for which there is no cure. The fragility fractures it causes are most common in people over the age of 50. They are not, however, an inevitable part of growing old. A healthy lifestyle and bone protecting treatments - prescribed when a person has been diagnosed with osteoporosis - can reduce their risk of suffering a fragility fracture by up to a half.

4. 250,000 people in Scotland currently have osteoporosis, a figure which is likely to rise as the average age of the population increases. In the UK, 1 in 2 women and 1 in 5 men will suffer a fracture at some point after the age of 50, mainly because of poor bone health.

5. Fragility fractures are hugely expensive to treat and care for and are growing in prevalence: each year, Scotland spends £192 million treating and caring for people with hip fractures. Between 1998/99 and 2007/08:

- The number of men admitted to hospital for a hip fracture increased by 39%
- The number of women admitted to hospital for a hip fracture increased by 8%
- The overall rise for both men and women was 15%
- The number of bed days attributed to hip fractures increased by 12%.

6. Projections show that on current trends, by 2036 there could be as many as 19,000 hospital admissions for hip fracture a year in Scotland - this would be an increase of 43% on 2008 admissions.

7. The number of bed days attributed to hip fractures will rise sharply; in Scotland, they will increase by 13% between 2008 and 2036. If we do not take steps now to improve the prevention, diagnosis, treatment and care of osteoporosis, the number of people affected by fractures will rise steeply in just a few years - the cost of treating and caring for hip fractures in Scotland could top £835million by 2036.

Further, what planning is being done, or should be done, to address this?

8. Much can be done to prevent fragility fractures, through the proper identification, treatment and care for people who have osteoporosis and/or are at risk of falls; clinical trials have shown that a range of bone protecting treatments, many of which are available on the NHS in Scotland, reduce a person's chances of fracture by up to 50%.

9. The first-line bone protecting treatment is generic alendronate; it is cheap and effective and is currently available for £14 per patient per year. Other treatments for osteoporosis are also now off-patent, with more due to follow in the short-term.

10. The best way of ensuring that fractures are prevented is through a Fracture Liaison Service (FLS). FLSs can be based in fracture units in hospitals, or linked to a number of GP surgeries within primary care. The hub of each FLS is often a specialist nurse, who is specifically trained to identify and record every patient over the age of 50 who has suffered a fragility fracture. The specialist nurse will ensure that people diagnosed with osteoporosis are offered Scottish Intercollegiate Guidelines Network (SIGN) and Scottish Medicines Consortium (SMC)-recommended treatments where necessary; a similar model is used to co-ordinate stroke services. The specialist nurse will also often contact people again once their treatment has begun, to support them in adhering to and complying with their medication.

11. The FLS model of care has been pioneered in Greater Glasgow and Clyde where a world-leading service is in place; it is regularly cited as a model of best practice throughout the UK. Providing an effective FLS relies upon delivery of seamless integrated care between the acute sector and other health and social care organisations.

12. There are four significant published public policy documents which support the implementation of comprehensive FLS throughout Scotland:

Scottish Government delivery framework for adult rehabilitation prevention of falls in older people (www.sehd.scot.nhs.uk/mels/HDL2007_13.pdf)

13. This directive, issued in 2007, makes the following action obligatory:

- All NHS Boards must have a combined falls prevention and bone health strategy, under which Community Health Partnerships (CHPs) can develop operational implementation strategies.
- CHPs need to appoint a falls prevention lead or co-ordinator, to work alongside the rehabilitation co-ordinator.

- CHPs need to develop an operational combined falls prevention and bone health implementation strategy, working within the NHS Board strategy and any wider Community Planning strategy.

NHS Quality Improvement Scotland: Up and about - pathways for the prevention of falls and fractures
www.nhshealthquality.org/nhsqis/files/up_and_about_finaljan10.pdf

15. Published in 2010, this document provides a detailed care pathway for the prevention and management of falls and fragility fractures in Scotland; it advocates comprehensive falls and fracture services, including FLSs, for localities across Scotland. The pathway highlights the integral role that Fracture Liaison Nurses and Osteoporosis Nurses play in running effective FLS. The National Osteoporosis Society was part of the steering group which drafted the document.

Social Care and Social Work Improvement Scotland (SCSWIS): Managing falls and fractures - good practice self-assessment resource

www.scswis.com/index.php?option=com_content&task=view&id=7906&Itemid=725

17. This is a working resource which will help staff in care homes to assess how well the management and prevention of falls and fracture is being addressed in their service. It aims to provide the answers to many of the questions care home managers have, and can also act as an educational tool for new or existing care home staff. It provides practical help, guidance and tools and signposts to resources available online.

The good practice self-assessment resource comprises:

- an introduction to the topic of falls and fractures in care homes
- self-assessment guidance and form
- Information, guidance and tools to help improve care

Quality and Outcomes Framework (QOF)

18. From April 2012, osteoporosis has been included in the QOF giving GP practices financial incentives for diagnosing and treating osteoporosis in their patients. This follows a seven year campaign led by the National Osteoporosis Society. The new indicators mean that GP practices will receive funding for:

- Producing a register of patients (a) aged 50-74 years with a record of a fragility fracture after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan; or (b) aged 75 years and over with a record of a fragility fracture after 1 April 2012.
- Ensuring that patients on the register who are aged between 50 and 74 years, with a fragility fracture, in whom osteoporosis is confirmed on DXA scan, are treated with an appropriate bone-sparing agent.
- Ensuring that patients aged 75 years and over with a fragility fracture are treated with an appropriate bone-sparing agent.

What weight should be given during the annual budget process to demographic trends and projections?

19. In mitigating and adapting to the impact of the ageing population, it is crucial that resources are made available for NHS, public health and social care services which are proven to improve outcomes for older people. Priority should be given to those services which are proven to:

- keep older people well and independent for longer
- reduce admissions among older people into hospital and social care settings
- achieve net cost savings for the NHS and local authorities.

The data set out in our response to question 4 shows that FLS satisfies all three of these criteria.

What data is collected (and what should be collected) with respect to (a) health and social care services, and what use is made of this (or should be made) for forecast what funding is needed?

20. Comprehensive falls and fracture services are proven to be effective: Glasgow has had a city-wide FLS since 2002, which has operated in conjunction with a falls prevention service; the FLS was expanded to include the neighbouring Clyde region in 2009.

21. Studies on hip fracture incidence in the Greater Glasgow area show that between 1998 and 2008, the number of recorded hip fractures decreased by 7.3% from 1377 to 1276; further details can be accessed from: <http://library.nhsggc.org.uk/mediaAssets/OFPS/NHSGGC%20Strategy%20for%20Osteoporosis%20and%20Falls%20Prevention%202006-2010%20An%20Evaluation%20Neil%202009.pdf>

22. In comparison, in England, where only a third of NHS Trusts employ a Fracture Liaison Nurse, hospital admissions for hip fracture in those aged 65 and over increased by 17% between 1998/99 and 2008/09.

23. The Kaiser SCAL system in the United States uses a service model incorporating both primary and secondary fracture prevention; in 2009, the actual number of cases of hip fracture sustained by individuals aged 60 and over was recorded as 47.8% lower than the number that would have been expected had the system not been in place.

24. As part of the National Falls Programme in Scotland, between May and October 2011 all Community Health and Care Partnerships (CH(C)Ps) completed self-assessments of local arrangements for managing and preventing falls and fractures in older people. The key findings were as follows:

- Two thirds (66%) of CH(C)Ps provide a Fracture Liaison Service (FLS) for people over the age of 50; FLS provision remains higher in Scotland than the rest of the UK.
- There has been some improvement since the last Scottish FLS audit in 2009 - this found that 77.6% of the Scottish population had access to routine post fracture assessment; six NHS boards had board-wide access to post fracture assessment;

three NHS boards had limited access; and five NHS boards had no formal arrangements.

- However, the absence of an FLS or equivalent continues to be an issue in some areas, particularly in the islands and more rural Scottish NHS boards, where poor access to DXA scanning is also a drawback.
- A minority of falls prevention services in CH(C)Ps have formal links with FLSs (where they exist). These links include agreed referral protocols and pathways between services. This does not suggest an integrated approach to falls and bone health. It is also a less favourable finding than that of a 2009 audit which suggested that seven out of nine NHS boards with an FLS had established pathways with falls services. The report states that “this is an area of care where simple changes in practice could benefit older people at risk of falls and fractures considerably.

25. Dr Alastair McLellan, Consultant Endocrinologist at the Western Infirmary, Glasgow, has carried out a Scotland-wide audit of service provision for routine post-fracture assessment for secondary prevention of osteoporotic fractures; this was presented to MSPs by the National Osteoporosis Society in April 2009. The audit results show that 22% of the Scottish population have no access to routine post-fracture assessment for osteoporosis and future fracture risk.

26. These results highlight a significant health inequality between the future fracture risks of those patients who have and have not had their care co-ordinated by an FLS.

27. The financial impact of ensuring universal access to FLS for all inpatients and outpatients in Scotland was estimated in 2009. The cost of treating and caring for fracture patients amounts to millions of pounds for the NHS and social care in Scotland every year; Dr Alastair McLellan shows that, in comparison, the cost of ensuring universal, automatic post-fracture assessment for treatment for osteoporosis and secondary fracture prevention for all women and men over the age of 50 in Scotland is £747,000 recurring; this is in addition to £140,000 initial set-up costs.

28. The UK Department of Health has published a suite of documents entitled ‘The Prevention Package for Older People’ (available for download from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh_103146); this provides NHS commissioners in England with the tools and evidence base they need to commission local care pathways which include FLSs; these are consistent with the National Service Framework (NSF) for Older People for England, current NICE guidance and other accepted clinical guidance; the package estimates that:

- a comprehensive FLS serving a population of approximately 320,000 people will prevent 33 fragility fractures over a five-year period
- FLSs will save money for a local health and social care community; over a five-year period, an FLS will cost £234,181 to set up and maintain; in the same period, it will save £290,708 in treatment and care costs from averted fractures; this represents a net saving of £56,527.

29. These figures include all costs, incorporating consultant and nurse time, drug treatments, diagnostic scans, providing building space for the service, IT equipment, and costs associated with administration.

Health and social care

To what extent are preventative policies such as the Change Fund key to addressing demographic pressures on the provision of health and social care?

29. The National Osteoporosis Society welcomes policies such as the Change Fund which aim to improve services for older people by shifting care towards anticipatory care and preventative spend. Mitigating and adapting to demographic change in Scotland will require long-term financial planning for Government, the NHS and local government.

30. We call for all NHS Boards to fund an FLS for every local area in Scotland. For the minority that do not do so currently, this will require an initial capital investment. Positive outcomes for both older peoples' health and wellbeing and for NHS and local authority budgets will, however, be achieved in subsequent years. Those boards which do fund an FLS must continue to do so. Short-term financial decisions to cut such FLSs will incur greater costs in the long-term.