BROKEN BONES, BROKEN LIVES:
A roadmap to solve the fragility fracture crisis in the United Kingdom
With fragility fractures affecting one in three women and one in five men aged 50 or above, nearly everyone has a family member or friend who has been affected by a fragility fracture. Yet how many of us stop to question the true cause of fragility fractures and simply assume them to be a ‘normal’ sign of ageing rather than the result of weakened bone? How many of us understand that an initial fracture may be a gateway to further fractures and should be treated as a warning sign and prompt us to seek out preventative treatment?

As the UK population ages, the incidence and contribution of fragility fractures to the overall healthcare spend continue to increase. In 2017, over half a million fragility fractures occurred in the UK with an associated healthcare cost of £5.25 billion. This annual expenditure is predicted to increase by 30%, to £6.83 billion, by 2030.

Any fracture is painful and distressing and can disrupt normal activities. An initial fracture significantly increases the risk of subsequent fractures and can trigger a negative spiral of healthcare dependence, escalating expense and impaired quality of life, despite the existence of treatments and programmes for secondary prevention of fragility fractures.

This report, Broken bones, broken lives: A roadmap to solve the fragility fracture crisis in the United Kingdom, explores the clinical, societal and cost burden associated with fragility fractures in the UK. The findings provide evidence that, despite the availability of effective preventative therapies and management approaches for fragility fractures, more than 50% of UK women aged 50 years or above do not receive appropriate care in the year following a hip fracture.

Much has been done over recent years to highlight the impact and improve the management of falls and fragility fractures in the UK, such as the development of a national consensus statement by Public Health England, best practice care pathways by the National Osteoporosis Society (NOS) (e.g. RightCare pathway, RightCare Scenario) and national databases (e.g. the Royal College of Physicians’ Falls and Fragility Fracture Audit Programme). However, despite these efforts, there remains an urgent need to recognise fragility fractures as a public health priority and to support the National Health Service (NHS) to integrate secondary fracture prevention and management as a core component of healthy ageing.

In addition to providing the latest state of play of fragility fracture care, the report serves as a roadmap, which includes policy recommendations that can assist national and local policymakers in offering the best possible care for their citizens in order to reduce the number of fractures and their impact on patients and the NHS.

Cyrus Cooper, IOF President
Did you know that...

The silent burden of fragility fractures for individuals and healthcare systems

- Fragility fractures affect men and women across the UK
  - Prevalence of osteoporosis in the UK
  - Lifetime risk of fragility fractures
  - Fragility fracture incidence

- Fragility fractures incur substantial healthcare costs
  - Fragility fractures are associated with significant healthcare costs
  - Fragility fractures place a high burden on patients and healthcare systems

- Fragility fractures have a multifaceted impact on the individual and society
  - Reduced independence and lifestyle impairment
  - Fragility fractures can significantly impact the working population
  - Patients suffering fragility fractures depend on care from family and friends

Fragility fractures in the context of public health priorities

Fragility fractures are a growing challenge in the public health landscape

- Fracture-related costs are set to rise
- Fracture-related patient burden is set to increase

Effective management can improve outcomes and reduce costs

- One fragility fracture leads to another
- Most eligible patients do not receive treatment to prevent fragility fractures following their first fracture
- Multidisciplinary models for secondary fracture prevention can contribute to closing the treatment gap
- FLSs are a cost-effective option for patient management

A roadmap to solve the fragility fracture crisis in the UK

- Improve local services
- Strengthen national policy
- Raise awareness – change behaviour

Acknowledgements

- IOF Steering Committee
- IOF Consultation Panel

Reference list
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMD</td>
<td>Bone Mineral Density</td>
</tr>
<tr>
<td>CI</td>
<td>Confidence interval</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>CTF®</td>
<td>Capture The Fracture®</td>
</tr>
<tr>
<td>DALY</td>
<td>Disability-adjusted life year</td>
</tr>
<tr>
<td>EU6</td>
<td>France, Germany, Italy, Spain, Sweden and the UK</td>
</tr>
<tr>
<td>FLS</td>
<td>Fracture Liaison Service</td>
</tr>
<tr>
<td>FLS-DB</td>
<td>Fracture Liaison Service Database</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross domestic product</td>
</tr>
<tr>
<td>ICER</td>
<td>Incremental cost-effectiveness ratio</td>
</tr>
<tr>
<td>ICUROS</td>
<td>International Costs and Utilities Related to Osteoporotic Fractures Study</td>
</tr>
<tr>
<td>IOF</td>
<td>International Osteoporosis Foundation</td>
</tr>
<tr>
<td>LTC</td>
<td>Long-term care</td>
</tr>
<tr>
<td>MOF</td>
<td>Major osteoporotic fracture (hip, spine, humerus or forearm fractures)</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NOS</td>
<td>National Osteoporosis Society</td>
</tr>
<tr>
<td>QALY</td>
<td>Quality-adjusted life year</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

This report provides an overview of the burden and management of fragility fractures in the UK and compares the national reality to that of the EU6 nations (France, Germany, Italy, Spain, Sweden and the UK). The report not only aims to highlight the burden and challenges posed by fragility fractures, but also to signpost opportunities for increased efficiencies in fragility fracture management and to realise improvements in patient care.

As the UK’s population ages, the challenge of preserving the independence and active lifestyles of the ageing population has become a multifaceted challenge that technology, social initiatives and healthcare policy can help tackle.

With over half a million new broken bones occurring in the UK in 2017, fragility fractures are a major obstacle to healthy ageing, impacting the independence and quality of life of 3.5 million women and men living with osteoporosis in the UK.

Fragility fractures can be prevented, but their prevention and management have long been neglected despite the massive associated costs for the NHS (£5.25 billion in 2017) and these are set to increase to £6.83 billion by 2030.

The burden of fragility fractures in the UK exceeds that for chronic obstructive pulmonary disease (COPD) and ischaemic stroke.

After a fragility fracture, individuals are five times more likely to experience a second fracture within the next 2 years. Despite this, less than half the women who sustain a hip fracture at or after the age of 50 go on to receive treatment for osteoporosis in the following year. Not unique to the UK, this massive treatment gap is observed consistently across Europe, reflecting the low importance that continues to be given to the escalating issue of fragility fractures in our ageing society.

With fragility fracture incidence in the UK predicted to increase by 26% by 2030, now is the time to break the cost spiral, and take action to put an end to the dire consequences of fractures on patients.

In its 70th year, the NHS, like many healthcare systems throughout the world, faces challenges that threaten its ability to make necessary change. These challenges include the rising demand from a growing and ageing population, the changing pattern of illness and need, and the financial and operational viability of its service model. However, these challenges are outweighed by opportunities, such as advances in new medicines and technology, the ability to harness data and information, and improvements in our understanding of different care models that are integrated and centred around patient need.

Policies should continue to play a significant role in promoting, funding and implementing innovative solutions for post-fracture care in the UK. For example, coordinated care models for patients following a fracture, such as a ‘Fracture Liaison Service’ or FLS (the first of which was created in Glasgow, Scotland), have proven to be both clinically effective and cost-effective: they have been shown to reduce further fractures, and lessening the burden on both healthcare and individuals at a reasonable investment cost. Besides FLSs, additional policy solutions adapted to the specificities of the UK healthcare system and policy landscape should also be considered to drive the improvements needed in fracture care.

The fragility fracture roadmap for the UK prioritises policy activities that can make a difference for patients with fragility fractures, focusing on: local service improvement, strengthening of national policy and raising awareness to change behaviour.
DID YOU KNOW THAT...

• Osteoporosis (which means ‘porous bone’) is a disease that weakens the density and quality of the bone, thus increasing the risk of fracture. The loss of bone is symptomatically silent and progressive, until the first fragility fracture occurs due to a low-trauma event, such as a fall from standing height or even a minor bump.

• One in five men and one in three women aged ≥50 years will experience a fragility fracture in their remaining lifetime.

• A fragility fracture is a warning sign that has to be taken seriously: a fracture increases the risk of a subsequent fracture, which can occur at a different site.

• It is not only important to treat the existing fragility fracture but also to prevent subsequent breaks, i.e. secondary fracture prevention.

• “By missing the opportunity to respond to the first fracture, healthcare systems around the world are failing to prevent the second and subsequent fractures” (Professor Kristina Åkesson)

“Even sitting caused great pain; it was better to lie flat or stand. It even hurt to breathe.

David, UK"
The silent burden of fragility fractures for individuals and healthcare systems

The number of fractures and living with day to day pain made my life at times unbearable. I had to give up work, which made me feel a burden to my family.

Karen, UK

Fragility fractures affect men and women across the UK

Prevalence of osteoporosis in the UK

Approximately...

2.8 million women

0.7 million men

...3.5 million people in the UK have osteoporosis (assessed 2015).

Prevalence of osteoporosis in the UK (21.8% for women; 6.8% for men) over the age of 50 years is comparable to that of France, Germany, Italy, Spain and Sweden, which together with the UK are hereafter referred to as the EU6 nations.
Lifetime risk of fragility fractures

At the age of 50 years, the remaining lifetime risk for a major osteoporotic fracture (MOF) is slightly higher for women in the UK compared with other EU6 countries, but similar for men.\(^7\)

The lifetime risk of sustaining a fragility fracture varies for women and men, and by fracture site.

There is a marked difference in the risk of fracture between the EU6 countries, with Northern European countries having the highest fracture rates observed worldwide.

The reasons for the difference in fracture risk between countries are unknown and cannot be explained by differences in bone density. However, plausible factors include differences in body mass index, low calcium intake, reduced sunlight exposure and, perhaps the most crucial factor, socio-economic prosperity, which in turn may be related to low levels of physical activity.\(^12,13\)

Regardless of differences in fracture risk, the number of fractures in all countries is expected to increase due to an increasingly elderly population.

Lifetime risk of fragility fracture from the age of 50 years in the UK\(^2,7,12,14–20\)

![Graph showing lifetime risk of fragility fractures for women and men in the UK, with different fracture sites: Hip, Vertebral, MOF.](image-url)
**Fragility fracture incidence**

An estimated 520,000 fragility fractures occurred in the UK in 2017.⁶

**Estimated number of fragility fractures in the UK in 2017 and the EU6, by fracture category**

---

**UK: distribution of fracture type**

- Total fragility fractures in 2017: 0.52 million, of which 50% were MOFs
- 65% of fractures were Hip, 16% Vertebral, 19% Other

**EU6: distribution of fracture type**

- Total fragility fractures in 2017: 2.68 million, of which 51% were MOFs
- 65% of fractures were Hip, 15% Vertebral, 20% Other

The silent burden of fragility fractures for individual and healthcare systems
Fragility fractures incur substantial healthcare costs

Fragility fractures are associated with significant healthcare costs

In 2017, fracture-related costs totalled approximately £5.25 billion in the UK. Length of stay in secondary care following a fracture is an important driver of cost.

Estimated annual fracture-related costs in the UK in 2017

Fracture-related costs:²¹,²²

- mostly occur in the first year following a fracture
- differ between fracture sites and, to some extent, reflect the severity of fracture
- tend to be highest with hip fractures, as this is the most severe fracture site
Fragility fractures place a high burden on patients and healthcare systems

The burden of fragility fractures on individuals is demonstrated here with the annual loss of quality-adjusted life years (QALYs).

QALYs are a measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life. One QALY is equal to 1 year of life in perfect health. QALYs are calculated by estimating the years of life remaining for a patient following a particular treatment or intervention and weighting each year with a quality-of-life score (on a 0 to 1 scale). It is often measured in terms of the patient's ability to carry out the activities of daily life, and freedom from pain and mental disturbance.\(^{21}\)

The loss of QALYs as a result of fragility fractures varies across the EU6 countries. These differences are largely driven by variations in the risk of fractures and age distribution between countries.\(^6\)

The total health burden in 2017 due to fragility fractures in the UK is estimated to be 183,311 QALYs.
Fragility fractures have a multifaceted impact on the individual and society

Reduced independence and lifestyle impairment

A fracture not only affects people physically, but also emotionally. Knowledge of their increased fracture risk can negatively affect patients' outlook, causing them to change their levels of social interaction and to avoid certain activities: impairing their overall quality of life.24

Patients with osteoporosis may face dramatic changes in their lifestyle due to constant pain, fear of breaking another bone and the emotional insecurity that can result from the physical effects of fractures.25

- One in three people in long-term pain describe it as severe or unbearable, with only half of patients reporting having effective medication to help manage it25
- One in four people with osteoporosis who were of working age at diagnosis have had to give up work, change their job or reduce their hours25
- 54% of patients with a fragility fracture have experienced height loss or a change in their body shape, leading to loss of confidence25
- 42% of people said their osteoporosis has made them feel socially isolated, with one in three people admitting to seeing their friends and relatives less often than they used to25

Reduced independence can be one of the most distressing outcomes for fracture sufferers. The disability associated with hip fractures can be severe. A month after experiencing a hip fracture, 8% of patients will have died and only half will have returned home. Of those who survive:

- 60% have difficulty with activities, such as feeding, dressing and going to the toilet
- 80% are unable to shop, garden or climb stairs
- 50% of people who previously walked unaided will no longer be able to walk independently in the year following a hip fracture

The long-term loss of independence and mobility can put physical, emotional and financial strain on patients, as well as their relatives and friends, potentially leading to the need for institutional care, particularly in older age groups.26

In the UK, an estimated 12% of patients are discharged to long-term care (LTC) after a hip fracture.27

The silent burden of fragility fractures for individual and healthcare systems
Across Europe, the proportion of patients that move into LTC within a year of sustaining a hip fracture increases with age, from 2.1% at age 50–60 years to 35.3% above 90 years.⁶

**Fragility fractures can significantly impact the working population**

Although fragility fractures mostly affect people in later life, an estimated 20% of fractures occur at pre-retirement age.² In 2017, a total of 7,615,719 sick days were taken across the EU6 as a result of fragility fractures; more than one-third of these (34%; 2,626,421 days) were taken by individuals of pre-retirement age living in the UK.²⁸
Patients suffering fragility fractures depend on care from family and friends

As a result of reduced mobility and ability to complete activities of daily living, individuals who have suffered a fragility fracture may rely on informal caregivers, such as family members or friends.

During the first year after a fracture, the hours of care provided by relatives vary greatly by fracture type and country:* The more serious the fracture, the more support is needed.

*To measure the average burden placed on informal caregivers per year, survey responses from ICUROS[29–31] were also used to determine the caregiver burden due to osteoporotic fracture. It was measured in terms of hours of care per year provided by relatives in ICUROS Europe (a substitute measure for the EU6), as well as selected countries.
In countries where cross-generational support is more established, the impact of fragility fractures on caregivers is generally higher.\textsuperscript{32}
Fragility fractures represent a health risk for individuals aged 50 or above. In these older individuals, the risk of being affected by osteoporosis is similar to that of having high cholesterol or blood pressure (two major contributors to heart disease that affect 54% and 44% of people aged 50 or above, respectively). Fragility fractures in the context of public health priorities

The lifetime risk of suffering a MOF at age 50 years in the UK (35% for women; 31% for men) is markedly higher than the lifetime risk of a stroke for women (20%) and men (14%) in Europe.34,35

My bones became worse and I suffered a further three fractures in my vertebrae, which has had a life changing colossal impact on my life. Clive, UK

Lifetime risk of fragility fracture from the age of 50 years in the UK and the equivalent risk of stroke in Europe 2,7,12,14-20
The fragility fracture burden in the EU6 is greater than that of many other chronic diseases (including COPD). It is surpassed only by ischaemic heart disease, dementia and lung cancer.\textsuperscript{36}
Osteoporosis is the fourth leading cause of chronic disease morbidity, rising from a ranking of sixth in 2009. Across the EU6, fragility fractures now account for more than 2.6 million DALYs (a measure of the impact of a disease or injury in terms of healthy years lost) annually, more than for hypertensive heart disease or rheumatoid arthritis. In the UK, an estimated 24 DALYs are lost per 1,000 individuals aged over 50 years due to fragility fractures. The UK burden exceeds the EU6 average (21 DALYs per 1,000 people) and that associated with other major chronic diseases of ageing (ischaemic stroke and COPD).
Fragility fractures in the context of public health priorities
An ever-growing public health challenge is emerging: 520,000 fragility fractures occurred in the UK in 2017, and the annual incidence is estimated to increase to 660,000 by 2030.\textsuperscript{6}

The projected increase in fracture incidence in the UK (26.2\%) is mirrored across the EU6 (23.3\%):\textsuperscript{6}

FRAGILITY FRACTURES ARE A GROWING CHALLENGE IN THE PUBLIC HEALTH LANDSCAPE

It’s the everyday things that make me so frustrated, getting into and out of the shower is impossible. Some days I could just scream with the pain.  
Jane, UK

\begin{figure}
\centering
\includegraphics[width=\textwidth]{fragility_fractions.png}
\caption{Estimated number of fragility fractures by fracture category in the UK in 2017 and 2030}
\end{figure}
Fracture-related costs are set to rise

Fracture-related costs in the UK are projected to increase by almost one-third between 2017 and 2030.⁶ The projected increase in fracture costs in the UK over this period exceeds the overall average of 27.7% for the EU6 nations.⁶

Estimated annual fracture-related costs in 2017 and 2030, and percentage change for the UK

Although hip fractures make up 1/5 of total fractures, they are estimated to incur an estimated 58% of total fracture-related costs
Fracture-related patient burden is set to increase

Based on population projections, the QALY losses associated with fragility fractures will increase between 2017 and 2030 across the EU6, with the UK facing the greatest percentage increase over the time period (28.2%).

Total annual loss of QALYs by country in 2017 and 2030, and percentage change

- UK: Δ28.2%
- France: Δ26.4%
- Germany: Δ22.4%
- Italy: Δ24.7%
- Spain: Δ29.8%
- Sweden: Δ27.2%

Δ percentage change for all fragility fractures
If the fracture I suffered in my spine had been spotted earlier than it was, I would have been spared a great deal of pain and suffering.  

Christine, UK

One fragility fracture leads to another

For women aged 50 to 80, after their first fragility fracture, their risk of a subsequent fracture within the first year after a fracture is five times greater than women who have not had a prior fracture.37

Subsequent fracture risk is highest in the first 2 years following an initial fracture, when there is an imminent risk of another fracture at the same, or other, sites.38 This is why it is critically important to identify patients as soon as possible after fracture to optimise fracture prevention treatments and keep the patient from having another fracture.

Similar patterns of imminent fracture risk have been observed in most countries evaluated,21,22 but between-country comparisons are limited by data availability.

Relative risk of all subsequent fractures calculated as a mean from the first fracture (grey line) and per separate year of follow-up (orange line)

Adapted from van Geel et al.37
Most eligible patients do not receive treatment to prevent fragility fractures following their first fracture

With appropriate medical treatment, many fragility fractures can be avoided. The guidelines recommend that all patients should receive treatment after suffering a fragility fracture.\textsuperscript{39-41} Unfortunately this is not always the case with \textbf{60–85\% of women across the EU6 not receiving treatment following a fracture} and more than 50\% of UK women aged 50 or above who sustain a hip fracture not being prescribed pharmacological treatment for osteoporosis in the following year.\textsuperscript{6}

In the UK, the treatment gap was markedly lower after hip fracture (49\%).\textsuperscript{6}

### Proportion (\%) of female patients (50 years and above) untreated within a year of osteoporotic fracture\textsuperscript{6,42,43}

<table>
<thead>
<tr>
<th>Fracture types by country</th>
<th>Women aged 50 years and above (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td></td>
</tr>
<tr>
<td>France</td>
<td>![Bar graph for France]</td>
</tr>
<tr>
<td>Germany</td>
<td>![Bar graph for Germany]</td>
</tr>
<tr>
<td>Spain</td>
<td>![Bar graph for Spain]</td>
</tr>
<tr>
<td>Sweden</td>
<td>![Bar graph for Sweden]</td>
</tr>
<tr>
<td>Hip</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>![Bar graph for Spain]</td>
</tr>
<tr>
<td>Sweden</td>
<td>![Bar graph for Sweden]</td>
</tr>
<tr>
<td>UK</td>
<td>![Bar graph for UK]</td>
</tr>
</tbody>
</table>

Effective management can improve outcomes and reduce costs.
Multidisciplinary models for secondary fracture prevention can contribute to closing the treatment gap

Post-fracture coordinated care models, such as a Fracture Liaison Service (FLS), are multidisciplinary healthcare delivery models for secondary fracture prevention. Systematically, they aim to identify, diagnose and treat (by referral) all eligible patients within a local population who have suffered a fragility fracture, with the aim of reducing risk of subsequent fractures. In the FLS model, care is usually coordinated by a dedicated, specialist nurse who helps patients navigate the way through the various departments of relevance (e.g. orthopaedic surgery, radiology and primary care). The FLS concept was first developed and implemented in Scotland and has grown in popularity around the world due to its effectiveness in preventing secondary fractures.44

Post-fracture coordinated care models, like FLSs, offer the potential for a cost-effective care delivery model that reduces the risk of re-fracture and mortality by increasing the number of patients being treated and improving adherence to treatment.44-50 Data published from the FLS in Glasgow, Scotland, showed that FLSs are cost-effective for the prevention of further fractures in fragility fracture patients, resulting in fewer fractures and cost savings for healthcare systems.44

A recently published systematic literature review and meta-analysis based on 159 scientific publications highlighted the benefits of FLSs.51

<table>
<thead>
<tr>
<th>Outcome measure51</th>
<th>Effect of FLS (absolute change)</th>
<th>95% CI</th>
<th>Duration of follow-up (months)</th>
<th>Number of studies included</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMD testing</td>
<td>+24%</td>
<td>0.18 to 0.29</td>
<td>3–26</td>
<td>37</td>
</tr>
<tr>
<td>Treatment initiation</td>
<td>+20%</td>
<td>0.16 to 0.25</td>
<td>3–72</td>
<td>46</td>
</tr>
<tr>
<td>Treatment adherence</td>
<td>+22%</td>
<td>0.13 to 0.31</td>
<td>3–48</td>
<td>9</td>
</tr>
<tr>
<td>Re-fracture rate</td>
<td>–5%</td>
<td>–0.08 to –0.03</td>
<td>6–72</td>
<td>11</td>
</tr>
<tr>
<td>Mortality</td>
<td>–3%</td>
<td>–0.05 to –0.01</td>
<td>6–72</td>
<td>15</td>
</tr>
</tbody>
</table>

BMD, Bone Mineral Density

Effective management can improve outcomes and reduce costs.
A meta-analysis demonstrated that adoption of the 3 “I” model, with core priorities of Identify, Investigate and Intervene, offered greater effectiveness in patient assessment and treatment than 0–2 “I” models.

<table>
<thead>
<tr>
<th>Model</th>
<th>Identify</th>
<th>Investigate</th>
<th>Intervene</th>
<th>BMD Testing</th>
<th>Osteoporosis Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 “I”</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>79%</td>
<td>46%</td>
</tr>
<tr>
<td>2 “I”</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
<td>60%</td>
<td>41%</td>
</tr>
<tr>
<td>1 “I”</td>
<td>✔️</td>
<td></td>
<td></td>
<td>43%</td>
<td>23%</td>
</tr>
<tr>
<td>0 “I”</td>
<td></td>
<td></td>
<td></td>
<td>No studies</td>
<td>8%</td>
</tr>
</tbody>
</table>

Adapted from Ganda et al.

The analyses by both Ganda et al. and Wu et al. showed dramatic increases in BMD testing and osteoporosis treatment initiation, which further supports the value of post-fracture care coordination to prevent fragility fractures and reduce the overall cost of care for these patients.

Data from the UK’s established FLSs, indicate that:

- During the first 10 years of its existence, the FLS of the Glasgow University teaching hospitals assessed 50,000 patients and contributed to a 7.3% reduction in hip fracture rates, compared with a parallel increase of 17% in England.

- A Glasgow-style FLS could be implemented across the UK for as little as 0.6% of the current annual hip fracture costs.

Capture The Fracture® (CTF®): A global initiative of IOF

CTF® aims to ‘facilitate the implementation of coordinated, multidisciplinary models of care for secondary fracture prevention’.

CTF® has created a set of internationally endorsed standards and guides for best practice to bridge the gap between FLS providers and to help in the development and implementation of new FLSs. CTF® includes the largest network of individual FLS providers in the world.

Providers undergo a CTF® audit to determine service quality, with a gold, silver or bronze star awarded.

There are huge variations between and within countries in terms of the availability of coordinated care models. A CTF® survey reported that such models only existed for 2.8% of responders in Italy and up to 37.5% of responders in Sweden for hospital referrals, reducing to 1–10% for general practitioner referrals. In contrast, in the UK, the NOS estimated that 55% of the UK population has access to an FLS.
FLSs are a cost-effective option for patient management

In the UK, all relevant professional organisations\textsuperscript{54}, the National Osteoporosis Society\textsuperscript{65} and policymakers\textsuperscript{56,57} have recognised the need for universal access to FLSs. The National Osteoporosis Society has developed core standards that every FLS should meet to ensure that correct identification, investigation, information, intervention and integration with primary care are achieved, within a framework of quality, to the long-term benefit of fracture patients – the \textit{5IQ approach}. By adopting these standards, evidence-based best practice can be replicated effectively across the UK to reduce the burden of fractures while improving outcomes for patients and ensuring appropriate use of NHS resources.

In the UK, the cost per QALY of improving patient outcomes within an FLS has been estimated to be:\textsuperscript{58}

\begin{center}
\textbf{£22,709–30,000 per QALY saved; ICER post-hip fracture}
\end{center}

ICER, incremental cost-effectiveness ratio (a statistic used to summarise the cost-effectiveness of a healthcare intervention)

The NOS estimates that 55\% of the UK population currently has access to an FLS. A recent health economic analysis suggested that up-scaling FLS provision to cover all individuals aged over 50 years in the UK could prevent an estimated 5,686 subsequent fragility fractures every year and achieve net cost savings of £1.2 million a year:\textsuperscript{6}

\begin{center}
\textbf{Cost implications of extending an FLS to all individuals over 50 years in the UK}
\end{center}

\begin{itemize}
\item 5,686 fractures
\item Cost reduction
\item 2,705 QALYs
\item £1.2 million
\item QALYs saved
\item Health and social care benefit of closing the gap:
\item £931,966 per 100,000 population over 5 years
\end{itemize}

The World Health Organization\textsuperscript{59} provides guidance on how an intervention with a benefit expressed in QALY value equivalent to 1 year’s gross domestic product (GDP) per capita or less is considered to be reasonable expenditure, representing the likelihood of achieving at least 1 additional year of healthy life per capita.

With the UK GDP estimated to be £39,000–40,000,\textsuperscript{60} FLSs not only offer \textit{clear cost-effectiveness and cost savings for the NHS}, but also the possibility of improved care for the UK population.
A ROADMAP TO SOLVE THE FRAGILITY FRACUTURE CRISIS IN THE UK

Believe me when I say living with these fractures is a nightmare that never goes away.
Christine, UK

The NOS and the osteoporosis community acknowledges that due to the devolution of powers to Scotland, Wales and Northern Ireland legislatures and administrations there is national variation. However, this policy roadmap is aimed at national and local governments involved in health and social care policy making, health and social care commissioners, health and social care providers, professional bodies, drug companies and treatment/intervention provider decision makers, researchers and academics, and in fact to any innovators who are bold, brave and curious to want to make a difference to the lives of people with osteoporosis and the improvement of bone health in the UK.

Strengthen national policy

• Influence national and local government to direct future policies by prioritising the effective reduction of the burden from fragility fractures

• Influence organisations and individuals working with at risk groups and long-term conditions

• Have a clear evidence base for the prevention of osteoporosis, falls reduction and promotion of bone health and healthy ageing

• Establish consensus positions on the benefits of calcium intake, vitamin D status and physical activity for bone health and falls reduction and, through these, work towards improvements in national levels of vitamin D and participation in weight-bearing and muscle strengthening activities

• Include bone health messages in national public health prevention campaigns so that bone mass is maximised during early life and adulthood, and premature bone loss is minimised so that everybody has the best possible bone health throughout the course of their life

• Implement high-quality, sustainable, commissioning practices that will ensure FLSs are developed specifically to deliver nationally recognised standards and ongoing service improvement

• Develop and maintain a national audit of fragility fractures in England, Northern Ireland, Scotland and Wales at hospital and patient level

• Through the provision of data, improve the evidence-based service improvement for effective delivery of fracture prevention services and ensure sustainability of services

• Work in collaboration with NHS England and improvement initiatives and partners (NHS RightCare, GIRFT) to ensure that evidence and best practice is communicated and shared across all localities to inform commissioning decisions

• Routinely collect data on the mode of fracture, i.e. low trauma/fragility fracture as part of the standard NHS dataset across the UK

• Scope and develop plans to screen people at risk of osteoporosis

• Work to make osteoporosis a key part of improving health outcomes for the nation
Improve local services

- Involve people with osteoporosis, their family and carers, in co-creation and improvement of health and social care services as part of wider patient/public involvement and engagement practices
- Make people with osteoporosis and their families aware of how to gain maximum benefit from their health and social care services
- Commission, develop and support local osteoporosis and FLSs to ensure there is total UK population access to effective fracture prevention services, with specific focus on the identification of vertebral fractures
- Improve working across the interface of primary and secondary care
- Continuously improve the effectiveness, efficiency and patient experience of services against national guidance/standards, standards and audits (e.g. FLS Database, FLS-DB)
- Improve commissioning, management of data recording for FLSs and integrated falls services
- Provide high-quality, accredited education and support for healthcare professionals, policy makers and the public to help raise awareness of the importance of good bone health and fracture prevention

FLS-DB patient-level audit

Building on the success of the audit in driving quality of care for patients with a hip fracture, the Health Quality Improvement Partnership funded a mandatory national FLS-DB audit that was launched in 2016 and has published three reports covering facilities and patient-level FLS outcomes. The audit allows FLSs’ performance to be benchmarked and reported to payers, and for key service components to be identified and prioritised for service improvement and impact on patient care.

Performance of 50 FLSs supporting 42,589 patients with a fragility fracture in 2016

1 in 2 women and 1 in 5 men break a bone after the age of 50. Any fragility fracture approximately doubles the risk of another fracture. Fragility fractures can lead to loss of mobility and independence, social isolation and depression.

**Identification** Case finding is critical to the success of an FLS. On average, FLSs submitted 40% of their estimated fragility fracture caseload to FLS-DB (varying from 2% to 120%).

**Initiation** Of the patients recommended anti-osteoporosis medication, 31% were on treatment within the first 16 weeks.

**Time to FLS** Assessment 67% of identified patients were assessed by the FLS within 90 days of fracture.

**Monitoring** Only 41% of patients who had been recommended anti-osteoporosis medication were contacted at 12-16 weeks post fracture. Monitoring is important because treatment must be taken over many years to be effective.

**Data completeness** 50% of FLSs had good levels of data completeness. This is vital to ensure that the audit reflects actual patient care and that the data support the report’s findings and recommendation. Defined as fewer than five fields with more than 20% of data missing.

Patient care can be improved and NHS costs reduced by effective implementation of FLSs.
Raise awareness – change behaviour

• Increase awareness and understanding of how and why to improve bone health so that people are motivated to change behaviour

• Increase access and participation in safe physical activity or exercise

• Empower those with osteoporosis, their friends, family and social networks to be advocates for change

• Ensure people know what good quality services look like and what to expect from their health and social care providers and demand it

• Ensure people with osteoporosis and their families and carers feel supported, and are empowered and motivated to live well despite the symptoms of osteoporosis and that they understand how to prevent future fractures so they can manage their condition optimally

• Work towards including mental wellbeing as a key element of care and support as the psychological effects of osteoporosis are recognised more

• Raise awareness of healthy diets that include adequate calcium to aid bone health

• The families and carers of people with osteoporosis need to be more aware of osteoporosis and its risk factors and be encouraged to seek out a diagnosis

• Encourage healthcare professionals and NHS managers to follow up-to-date evidence-based guidance on standards of osteoporosis care and FLS

• Ensure that FLS commissioning incorporates service improvement and participation in national patient-level audits as basic standards and requirements
ACKNOWLEDGEMENTS

IOF Steering Committee

Professor John Kanis, Emeritus Professor in Human Metabolism and the Director of the WHO Collaborating Centre for Metabolic Bone Diseases, University of Sheffield, UK

Professor Eugene McCloskey, Professor in Adult Bone Diseases, Department of Oncology and Metabolism, University of Sheffield, UK

Professor Nicholas Harvey, Professor of Rheumatology and Clinical Epidemiology, MRC Lifecourse Epidemiology Unit, University of Southampton, UK

Dr Kassim Javaid, Associate Professor in Metabolic Bone Disease, Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences, University of Oxford, UK

Fredrik Borgström (PhD), Associate Researcher, Medical Management Centre, Department of Learning, Informatics, Management and Ethics, Karolinska Institutet, Sweden and Partner at Quantify Research, Sweden

IOF Consultation Panel

France

Professor Bernard Cortet (GRIIO), Professor in Rheumatology, University Hospital Lille, France

Professor Thierry Thomas (SFR), Professor of Medicine and Head of the Rheumatology Department, University Hospital St. Etienne, France

Professor Laurent Grange (AFLAR), Professor in Rheumatology, University Hospital Grenoble, France

Germany

Professor Claus Glüer (DGO), Professor of Medical Physics, Department of Radiology and Neuroradiology, University Medical Center Schleswig-Holstein, Kiel University, Germany

Professor Andreas Kurth (DVO), Chief Orthopedic Specialist, Department of Traumatology, Orthopedics and Hand Surgery, Community Hospital Mittelrhein gGmbH, Germany

Professor Peyman Hadji (DVO), Head of the Department of Bone Oncology, Endocrinology and Reproductive Medicine, Krankenhaus Nordwest, Germany

Thorsten Freikamp (BfO), Managing Director, Federal Self-help Association for Osteoporosis (BfO), Germany

Italy

Professor Maria Luisa Brandi (FIRMO), Professor of Endocrinology and Metabolic Diseases and Director of the Operative Unit of Diseases of Mineral and Bone Metabolism, Medical School, University of Florence, Italy

Professor Stefano Gonnelli (SIOMMMS), Associate Professor of Internal Medicine and Director of the School of Specialization in Emergency Medicine and Urgency, University of Siena, Italy

Professor Giuseppe Sessa (SIOT), Professor of Orthopedics and Traumatology and Director of the Orthopedic Clinic of the Vittorio Emanuele Polyclinic, University of Catania, Italy
Spain

Dr Josep Blanch Rubio (SEIOMM), Clinical Director of the Institut Blanch de Reumatologia, Spain

Professor Adolfo Diez-Perez (SEIOMM), Head Emeritus of Internal Medicine at the Hospital del Mar, Autonomous University of Barcelona, Spain

Maria Antonia Robles Palacios, President of AECOSAR, Spain

Dr Santiago Palacios (FHOEMO), Director of Instituto Palacios, Salud y Medicina de la Mujer, Spain

Sweden

Professor Mattias Lorentzon (SVOS), Professor in Geriatric Medicine, Institute of Medicine, University of Gothenburg, and Chief Physician, Osteoporosis Clinic at the Sahlgrenska University Hospital, Sweden

Lisa Keisu Lennerlöf (Osteoporsforbundet), Chair of Osteoporsforbundet, Swedish Osteoporosis Association, Sweden

UK

Professor Cyrus Cooper, Professor of Rheumatology and Director of the MRC Lifecourse Epidemiology Unit, University of Southampton, UK and Professor of Musculoskeletal Science at the NIHR Musculoskeletal Biomedical Research Unit, University of Oxford, UK

Fizz Thompson (NOS), Clinical and Operations Director at National Osteoporosis Society, UK

Dr Celia L Gregson, Consultant Senior Lecturer and Arthritis Research UK Clinician Scientist, Musculoskeletal Research Unit, Bristol Medical School, University of Bristol, UK
1. NOF. What is osteoporosis? Available at: https://www.nof.org/patients/what-is-osteoporosis/osteopedia-2/. Last accessed August 2018.


56. HC Deb. [Parliamentary Written Answer]. 17th November 2014. 213484W.

57. HC Deb. [Parliamentary Written Answer]. 11th February 2015. 223302W.


Our vision is a world without fragility fractures, in which healthy mobility is a reality for all.