***This template***

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# National Osteoporosis Society

# The case for investing in a Fracture Liaison Service for [enter name of organisation]

The cost to the NHS for fragility fractures is significant and will continue to grow as the UK population ages.

Fracture Liaison Services (FLS) ensure that patients are assessed after fragility fracture and offered secondary fracture prevention. There is strong evidence to demonstrate that investment in fracture liaison services results in improved quality of care and has financial benefits for commissioners of health and social care.

A FLS is a way to reduce the number and cost of unplanned admissions and to make a significant reduction in morbidity and mortality for older people.

The National Osteoporosis Society estimates that once cost of service provision has been considered, the estimated financial benefits to the health and social care economies over the next 5 years for **[enter name of CCG]** are £ **[use the** [NOS Benefits Calculator](http://benefits.nos.org.uk) **to determine this figure]** million, with £**[use the** [NOS Benefits Calculator](http://benefits.nos.org.uk) **to determine this figure]**million in NHS only benefits.

The FLS model, as recommended by Public Health England, as an evidence-based, cost effective, preventative intervention that can help to improve the health of the population and reduce health and care service demand1. The current provision of fragility fracture care is not consistent throughout the UK. In 2014, only 42% of local health economies in the UK provided any form of FLS2,3. A systematic FLS approach will correct this unacceptable variation in care.

**[State the current provision of FLS in your CCG locality]**

**[State level of engagement from senior clinicians at your hospital on implementing an FLS]**

**Suggested Action:**

* Invest in an effective Fracture Liaison Service at **[enter name of organisation]**

**Background**

Osteoporosis is the most common chronic bone disease affecting both women and men; characterised by low bone density and affecting approximately 3 million people in the UK4. It is common in people aged over 50 and the clinical manifestation of this disease is fragility fracture, with 1 in 2 women and 1 in 5 men over the age of 50 expected to break a bone during their lifetime5. Just 22% of people with osteoporosis think the NHS gives it the attention it deserves and 42% of people said their osteoporosis made them feel socially isolated6.

Demographic projections suggest that by 2025 the incidence of fragility fractures will have risen by 146,000 to 682,000 annually7. Effective secondary fracture prevention throughout the NHS would prevent over 46,000 avoidable fragility fractures (including nearly 20,000 hip fractures) over 5 years in the UK8.

**The Impact of Fragility Fractures**

It is estimated that currently every year in the UK there are more than 500,000 fragility fractures, that’s one every minute (1,400 a day)8. Over one year these fragility fractures comprise of approximately 79,000 hip fractures, 66,000 vertebral fractures, 69,000 forearm fractures and 322,000 other fractures7. The cost to the NHS of fragility fractures is significant and will continue to grow as the UK population ages9.

Hip fractures account for occupation of over 4,000 beds at any one time across England, Wales and Northern Ireland (more than 20% of orthopaedic bed occupancy in the UK), and an average length of stay of 20.3 days10. According to a survey by the National Osteoporosis Society, a fifth of women who have broken a bone break 3 or more before being diagnosed11. Current projections suggest that the number of hip fractures will increase by 65% in the next 20 years if secondary fracture prevention care does not improve12.

The estimated cost of treating and caring for patients experiencing new fragility fractures in a single year in **[insert name of organisation]** is **[use the** [NOS Benefits Calculator](http://benefits.nos.org.uk) **to get this figure]**8.  Note that this does not include the ongoing costs of treating and caring for patients that have fractured in previous years.

**What is a Fracture Liaison Service?**

A Fracture Liaison Service (FLS) is a multidisciplinary service, which aims to systematically identify, investigate, initiate treatment and integrate care for all eligible patients, over the age of 50 within a local population who have suffered a fragility fracture; with the aim of reducing their risk of subsequent secondary) fractures.

There are several models of effective Fracture Liaison Service. The service should be commissioned to meet local needs and fit with pathways already in place for the prevention and treatment of fractures. Integration with existing falls services is fundamental. Best practice guidelines for FLS are described in detail by the FLS Clinical Standards document published in 2015 by the NOS13.

There is strong evidence to demonstrate that investment in fracture liaison services results in improved quality of care for patients as well as having financial benefits for commissioners of health and social care14,15.

**Current FLS Provision**

The population of **[insert name of organisation]** includes **[get this information from the** [NOS Benefits Calculator](http://benefits.nos.org.uk)**]**8 people over the age of 50 and it has been estimated that over a 1 year period approximately **[get this information from the** [NOS Benefits Calculator](http://benefits.nos.org.uk)**]**8 of these patients could have a fragility fracture. Almost all registered patients within the **[insert name of CCG(s)]** area will access **[insert name of organisation]** for hospital services.

**Clinical Engagement & Implementation Support**

Clinical staff at consultant level are fully supportive of establishing a Fracture Liaison Service at **[insert name of organisation].** Implementation support is available from the National Osteoporosis Society. **[please edit this as appropriate]**

**Benefits**

Current national guidance provides evidence that effective case finding and use of appropriate drug therapies reduces the risk of future clinical fractures by up to 50%16. The FLS model has demonstrated that it is uniquely effective in managing patients’ risk factors and preventing secondary fractures by delivering assessments to 95-97% of at risk patients within the local population as opposed to 25% of patients in health economies with other service configurations14. Organisations with a FLS were found to have a 40% reduction in the 3-year risk of secondary fragility fractures to major bones and a 30% reduction of re-fracture to any bone, compared with organisations without an FLS17. Between 1998-2008 the Glasgow FLS (the first FLS in the world) saw hip fracture numbers in Glasgow reduced by 7.3% versus an almost 17% increase in England (1.8% per year)18.

The Commissioning for Value packs for **[insert name of CCG]** demonstrate, that measured against their 10 comparative CCGs there is opportunity for improvement, as there currently is19:

* **[Give examples here of opportunities within the relevant** [RightCare data pack](https://www.england.nhs.uk/rightcare/products/ccg-data-packs/where-to-look-packs/) **for the appropriate CCG(s), for example:**
* **A higher rate of non-elective admissions**
* **A higher rate of admissions relating to fractures where a fall occurred**
* **A lower proportion of patients age 75+ with fragility fracture treated with bone sparing agent]**

Over 5 years, if a full FLS was accessible to all eligible **[insert name of CCG]** patients, anticipated benefits would be8: **[The** [FLS Benefits Calculator](http://benefits.nos.org.uk) **will help you to calculate the benefits for inclusion in this document]**

* **[X]** fractures avoided: (**[X]** Hip, **[X]** other inpatient fractures, **[X]** other outpatient fractures, **[X]** clinical vertebral fractures) with the associated impact on acute trust and social care capacity and ‘flow’
* The average acute length of stay following a hip fracture at **[insert name of organisation]** is **[insert average acute length of stay following a hip fracture]**. From the table above, implementing an FLS will save up to approximately **[calculate total number of hip fractures prevented multiplied by the average acute length of stay]** bed days at **[insert name of organisation]**. This will also reduce the number of non-elective admissions and will help smooth patient flow through the hospital.
* Financial benefits of approximately £**[X]** million8

**Figure 1:** Benefits of having a FLS at **[insert name of organisation]:**

|  |  |
| --- | --- |
| **[insert name of organisation]** | |
| Total Population | **[X]** |
| Population >50 years | **[X]** |
| Total fractures prevented | **[X]** |
| Hip fractures prevented | **[X]** |
| **Acute care -** value of fractures prevented | **[X]** |
| **Community & primary care -** value of fractures prevented | **[X]** |
| **Social care -** value of fractures prevented | **[X]** |
| **Total -** value of fractures prevented | **[X]** |

**Costs:**

The National Osteoporosis Society has worked with many CCGs to implement fracture liaison services. From experience, annual service costs are approximately 40% of savings7. Depending on overheads and premises, break-even point usually comes within the second year of operation.

**Next Steps:**

**[please use this space to briefly set out your next steps. These could include:**

* **Stakeholder mapping**
* **Stakeholder meeting**
* **Gap analysis to understand current service provision**
* **Business case planning**
* **Service specification development]**

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# *Additional detail and references is available for all figures supplied by the National Osteoporosis Society. Note that for any information supplied by the National Osteoporosis Society there is no guarantee as to the accuracy of the or reliability of any information contained in this report and use of the information contained is at the user’s risk and no liability whatsoever is accepted by the National Osteoporosis Society.*