Table 1: Table of standards and summary results

|  |  |  |  |
| --- | --- | --- | --- |
|  | National Osteoporosis Society standards [2] | University Hospital Birmingham standards | Results |
| 1 | Identification: All patients ≥50 with a new fragility fracture or a newly reported vertebral fracture will be systematically and proactively identified. | All patients ≥50 attending UHB (inpatient or fracture clinic) with a fracture (excluding vertebral) will be identified by FLS. | 1773 reviewed in 1st year.  |
| 2 | Investigation: Patients will have a bone health assessment and their need for a comprehensive falls risk assessment will be evaluated within 3 months of the incident fracture. | All patients are assessed within 6 weeks of fracture. All patients deemed suitable for further assessment to have fracture and falls risk determined (FRAX®; FRAT outpatients only). DXA offered as appropriate. | 94% |
| 3 | Information: All patients identified will be offered written information about bone health, lifestyle, nutrition and bone-protection treatments. | Information on secondary prevention, actions taken and outstanding actions given to patient. | 100% of outpatients99% of inpatients |
| 4 | Intervention: Patients at increased risk of further fracture will be offered appropriate bone-protection treatments. | Appropriate treatment recommended (NICE TA161) [NICE]. | 94% of outpatients81% of inpatients |
| 5 | Intervention: Patients at increased risk of further falls will be referred for appropriate assessment or interventions to reduce future falls. | Falls risk assessed and information on prevention given and referrals made as appropriate. | 100% |
| 6 | Integration: Management plans will be patient-centred and integrated between primary and secondary care. | Information on actions taken and outstanding actions required given to GP (and patient). | 100% |
| 7 | Integration: Patients who are recommended drug therapy to reduce risk of fracture will be reviewed within 4 months of initiation to ensure appropriate treatment has been started, and every 12 months to monitor adherence with the treatment plan. | Telephone follow up to be done at 4 (originally 3 & 6 months) and 12 months to ensure treatments prescribed and taken and to exchange information. To call ≥3 times, if no answer after 3rd call to cease. | 44-45% successfully contacted (at 3 months)  |
| 8 | Quality: Core clinical data from patients identified by the FLS will be recorded on a database. Regular audit and patient experience measures will be performed and the FLS will participate in any national audits undertaken. | All identified patients will be recorded on database and local and national audits undertaken as required. Internal audit cycles initiated to review and develop service | 100% in database.Audit and patient surveys performed |
| 9 | Quality: The FLS team will have appropriate competencies in secondary fracture prevention and will maintain relevant Continued Professional Development (CPD). | All staff to attend relevant courses and competencies and training reviewed as part of appraisal process. Time and support provided to attend requisite training. | 100% FLS staff trained |
| 10 | Quality: The FLS should engage in a regular peer-review process of quality assurance. | Clinical peer review will be engaged with and relevant data published to improve FLS evidence base and facilitate development. | Peer review recently occurred |