The Prevention and Management of Fragility Fractures in Northern Ireland

Report of the fragility fracture working group

June 2009
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Executive Summary

A working group was established in October 2008 with the aim of designing a strategy to reduce the number and impact of fragility fractures in Northern Ireland.

Fragility fractures are associated with substantial disability, pain, reduced quality of life and death. They can impair the ability to live independently in the community and result in admission to nursing or residential care. Preventing the development of osteoporosis and early detection and treatment of osteoporosis will reduce the numbers of fragility fractures in Northern Ireland.

In Northern Ireland there has been a continuous audit of hip fractures treated in the Royal Victoria Hospital and Belfast City Hospital since 1997 with Altnagelvin and the Ulster Hospital joining in 2002. The audit shows that between 2002 and 2007 there was a 15% increase in the number of hip fractures from 906 in 2002 to 1037 in 2007. Between 1985 and 2007 there has been a 59% increase in hip fractures treated in Northern Ireland. The 5 year audit also showed that

- Females accounted for 75% of hip fractures and the mean age for hip fractures in females was 80.3 and 73.9 in males.
- The 30 day mortality was 7.1% and 1 year mortality was 22.6% for females and 27.8% for males
- At 12 months, of the patients admitted from their own homes, 69.5% had returned home, 9.4% were in nursing homes or other institution and 19.9% had died.
- Of the 1017 admitted from a nursing home. 38% had died within one year of treatment.

Conclusions

Northern Ireland is facing an unprecedented increase in the number of hip fractures in the next 5-10 years. The evidence base to support prevention and management of fragility fractures highlights the need for urgent action to raise awareness of how individuals can look after their bone health and ensure early detection and treatment of osteoporosis and fragility fractures. While many of the components of an effective fragility fracture prevention and management service are in place, there is a need for greater integration of services between hospital specialities and between primary and secondary care.
Recommendations

1. A Regional Public Awareness campaign to promote good bone health should be undertaken by the Northern Ireland Public Health Agency.

2. A Fracture liaison service for secondary prevention of fragility fractures should be established in all Trusts that have A&E and Minor Injury Services to ensure secondary prevention is offered to all patients who have suffered a fragility fracture.

3. All fracture units should be supported by an acute in-patient orthogeriatric service followed by an orthogeriatric rehabilitation service.

4. An Information infrastructure to support the monitoring of care and quality of fragility fracture services should be mandatory for all fracture units. This should be achieved by enhancement of the existing IT infrastructure in fracture units. There is a need to include all fragility fractures in this, especially those treated on an out-patient basis.

5. The prevention of falls is an important part of reducing fragility fractures. There is a need to ensure effective population approaches to preventing falls and care pathways are developed for older people needing further investigation and intervention.

6. The Directly Enhanced Service in Primary Care, to promote early detection and treatment of osteoporosis provides a major opportunity to address the impact of fragility fractures. GPs should be supported in achieving the DES requirements. It is important that this is done in partnership with secondary care.

7. The Long Term Condition Monies identified in the 2008-2011 funding cycle should be used to implement these recommendations.

8. An implementation schedule for NICE TA 160 and 161 should be developed which would include regional prescribing guidelines on initiation and maintenance of bisphosphonate therapy particularly in primary care together with medicines management support arrangements to promote patient adherence to prescribed medicines.

9. A regional implementation group should be established to oversee the implementation of these recommendations.
Background

Why is good bone health important?

Osteoporosis is a chronic progressive skeletal disorder, characterised by low bone mass resulting in an increase in bone fragility and susceptibility to fracture. Osteoporosis is a long term condition and is the most common disease of bone occurring mainly in older people, especially post menopausal females. The number of people with osteoporosis will increase as the population ages. Women are at a greater risk of osteoporosis than men, because of the decrease in oestrogen production after the menopause that accelerates bone loss. The number of women with osteoporosis increases from 2% at age 50 to more than 25% at age 80. The onset of osteoporosis is asymptomatic until a person has a fracture. There are effective therapies available to treat osteoporosis and reduce the risk of a subsequent fragility fracture.

In the next 12 years, the numbers of women in the 50+ age group will increase by 29%. However the numbers of women in the 85+ age group will increase by 63% (from 18,400 to 30,000).
The Working Group

A working group was established in October 2008 with the aim of designing a strategy to reduce the number and impact of fragility fractures in Northern Ireland. The terms of reference for the working group are shown in Appendix 1 and membership was drawn from Investing for Health partnerships and professionals from primary and secondary care.

This report provides an update on the prevention and management of fragility fractures in Northern Ireland. It identifies priority areas for service development and the need to raise awareness amongst the general population, of how they can maintain and improve their bone health. The report should be of interest to service commissioners and planners, providers of services, health improvement staff, community partnerships and the voluntary sector.

A major conference on the prevention and management of fragility fractures was held in Belfast on the 11th March 2009. The conference program and presentations can be accessed at www.southernifh.com/index.cfm/go/publications/go/publications/action/page/folder_id/249/Uploaded_In/0/Parent_Id/77

Impact of Fragility Fractures

Fragility fractures are associated with substantial disability, pain and reduced quality of life. They may also impair the ability to live independently in the community and result in admission to nursing or residential care. Fragility fractures are also associated with excess mortality in older people.

For services, the annual bed days due to fractures in England in the 60+ population are higher than those for heart disease and chronic obstructive pulmonary disease. In the UK it is estimated that 300,000 patients present to hospitals with fragility fractures each year with medical and social care costs, mostly relating to hip fractures, at approximately £2 billion. Mortality is 5-10% after one month and almost 30% after 1 year.

In Northern Ireland there has been a continuous audit of hip fractures treated in the Royal Victoria Hospital and Belfast City Hospital since 1997 with Altnagelvin and the Ulster Hospital joining
in 2002. This data shows that between 2002 and 2007 there was a 15% increase in the number of hip fractures from 906 in 2002 to 1037 in 2007. There is also significant month on month variation in fracture numbers e.g. in January 2006 there were 124 fractures treated compared to 61 in April 2007.

The osteoporotic life experience can be progressive from Colles fracture and symptomatic vertebral fractures to the major distress, dependency and disability of hip fracture (Figure 1). Health care costs are high and rising with increasing numbers of fragility fractures. The human costs of pain, deformity and loss of independence can be overwhelming.

Figure 1.

Fracture risk is multifactorial and reflects general frailty and falls risk as much as it does bone fragility. People living in nursing and residential homes have a three times higher risk of having a hip fracture compared to the general population. A quarter of patients with a hip fracture are admitted from institutional care.
Osteoporosis

Osteoporosis and fragility fractures are more likely in:

- Post menopausal females
- Being thin (BMI<22) or having a small frame
- Advanced age
- A family history of osteoporosis
- Eating disorders such as anorexia or bulimia
- A low-calcium diet
- An inactive lifestyle
- Cigarette smoking
- Alcohol intake of 4 or more units per day
- Use of certain medications e.g. corticosteroids and anti-convulsants
- Prolonged immobility
- Untreated premature menopause
- Rheumatoid arthritis
- Parental history of hip fractures
- Previous fragility fracture

Summary of the Evidence Base for Improving Bone Health and the Management of Fragility Fractures

Preventing the development of osteoporosis and early detection and treatment of osteoporosis will reduce the numbers of fragility fractures in Northern Ireland.

A variety of factors contribute to the development and maintenance of healthy bones. A well balanced diet, including foods rich in calcium and vitamin D, combined with weight bearing exercises such as brisk walking, skipping and running and positive lifestyle choices such as not smoking will all help to reduce the risk of osteoporosis. Osteoporosis can be prevented by building strong bones in childhood and adult years and ensuring adequate treatment of osteoporosis when it is detected in later life.

The BOA/BGS “Blue Book” publication “The Care of Patients with Fragility Fracture” describes best practice in the care and secondary prevention of fragility fractures. It includes standards for the care of hip fractures and how audit can be used to improve the performance of services and outcomes of care. The Blue Book has the support of the National Osteoporosis Society, Faculty of Public Health, Royal College of Nursing, Age Anaesthesia Association and the Society for Endocrinology.
In October 2008, NICE issued updated guidance, TA 160 and 161, on the primary and secondary prevention of osteoporosis. These replaced the 2004 NICE guidance TA 87.

The guidance described:

**Primary Prevention** as an “opportunistic identification, during visits to a healthcare professional for any reason, of postmenopausal women who are at risk of osteoporotic fragility fractures and who would benefit from drug treatment”. It is not a dedicated screening program.

**Secondary Prevention** is the “treatment for secondary prevention of fragility fractures in post menopausal women who have osteoporosis and have sustained a clinically apparent osteoporotic fragility fracture”.

For both primary and secondary prevention, NICE recommends first treatment options and alternative treatment options to take account of compliance, contraindications and intolerance of the medications.

NICE does not recommend the use of FRAX (a fracture risk assessment tool) as an aid to selecting patients to start treatment. This is being kept under review by NICE.
What needs to be done in Northern Ireland?

To tackle the problem of fragility fractures, Northern Ireland needs to ensure the following are in place:

- Greater Public Awareness of risk factors for osteoporosis and how to keep bones healthy
- A high quality fracture service supported by an orthogeriatric service for those who have suffered a fragility fracture
- A fracture liaison service for secondary prevention and active case finding for those at high risk in primary care
- An Information infrastructure to support quality care and prevention services
- Effective falls prevention services
- A Directly Enhanced Service in Primary Care to promote early detection and treatment of osteoporosis
- Effective medicines management for patients with osteoporosis and fragility fractures.

Public Awareness of Good Bone Health

Greater awareness is needed among the general population to help individuals build and maintain healthy bones to reduce their risk of falls and fragility fractures. These include information awareness campaigns about the importance of a healthy balanced diet and in particular the need for an adequate intake of calcium and vitamin D, which is needed to ensure effective absorption of calcium. Regular exercise in which the bones bear weight should also be promoted from childhood and individuals should be made aware of the risk factors for osteoporosis as part of general health and wellbeing awareness campaigns.

High Quality Fracture Services

Fragility fractures account for 70% of the inpatient and approximately 35% of the outpatient workload in a fracture unit. Fragility fractures are the core activity of any fracture service. It has been estimated that the numbers of fragility fracture will at least double in the next 40 years or so. This is consistent with the N. Ireland experience where the number of hip fractures (the commonest fragility fracture) increased by 59% between 1985 and 2007 and by 18% between 2002 and 2007 alone. The care of
Fragility fractures is very expensive (£70 million per year for all fragility fractures in N.I.) and the cost of dealing with complications even more so. A high quality fracture service is required to deal with fragility fracture and requires the following systems to be in place:

- Fragility fracture care is multidisciplinary and all hospital sites where inpatient fragility fractures are treated should appoint a local lead/champion from orthopaedics, elderly care medicine (e.g. orthogeriatrics) and anaesthesia. In-patient fracture units should have regular meetings of the wider multidisciplinary team including orthopaedics, elderly care medicine, nursing, physiotherapy, occupational therapy, fracture services manager and social services.

- High level specialist peri-operative acute medical care by an experienced orthogeriatrician.

- Sufficient beds in an orthopaedic/fracture ward to meet caseload. The majority of these patients have substantial co-morbidity and it is inappropriate to have them in outlying.

- Sufficient dedicated daytime fracture (trauma) theatre lists to meet caseload and a high level of experienced surgical and anaesthetic supervision.


- Participation in the National Hip Fracture Database (NHFD).

- A Fracture liaison service.

- Work towards assessing outcomes for non-hip fragility fracture inpatients and all outpatient fragility fractures.
Fracture Liaison Service

A Fracture Liaison Service (FLS) provides a secondary prevention service in an orthopaedic environment that promotes active case finding. This service is a proven mechanism for delivering secondary prevention to patients who have suffered a fragility fracture in order to reduce the risk of a subsequent fragility fracture, particularly of the hip. The lead clinician can be a geriatrician, orthopaedic surgeon, rheumatologist or endocrinologist. The service works closely with Dexa scanning services, falls services, Accident and Emergency (A&E) and Minor Injury Units (MIU) and uses locally agreed protocols for the management of osteoporosis.

A meta-analysis of the principle agents licensed for the treatment of osteoporosis indicates that a 50% reduction in fracture incidence can be achieved during three years of pharmacotherapy.

Every patient with any type of fragility fracture e.g. wrist, vertebral or hip should receive and assessment for secondary prevention therapy. In practice this means that any Trust that has an A&E or MIU needs to have a fracture liaison service (FLS).

Ortho-geriatric care

Early participation of a geriatrician in fragility fracture in-patient care improves outcomes for elderly patients. This ensures expert management of comorbidity pre and post operatively in fracture units and during rehabilitation.

Information Infrastructure

An information infrastructure to support the monitoring of care and quality of fragility fracture services should be mandatory for all fracture units. A structure has existed in N. Ireland for 7 years but is currently under pressure. Data from it relating to the Royal Victoria Hospital (soon Altnagelvin Hospital) is contributing to the National Hip Fracture Database (NHFD). The NHFD was set up to (i) focus attention on the role of the hip fracture as an indicator for the quality of the care and prevention of all types of fragility fracture and (ii) improve the care in hospital of people who have had a hip fracture, their recovery afterwards and the implementation of secondary prevention measures. It allows
comparison between hospitals in terms of casemix, length of stay, outcomes, and adherence to the standards laid down in the BOA/BGS Blue Book “The Care of Patients with Fragility Fracture”, 2007.

The Fracture Outcomes Research Units (FORU’s) are ideally suited to harvesting this data. They have been in place at the Royal Victoria Hospital, the Ulster Hospital and Altnagelvin Hospital for some years now and have substantial experience of this role. They are of proven value in (i) providing reports for commissioners, managers and clinicians and (ii) facilitating audits of specific aspects of hip fracture care. There is no equivalent structure in the fracture unit in Craigavon Area Hospital at present. Staffing levels at the UHD and Altnagelvin FORU’s have resulted in gaps in the data, substantially reducing its value. Additional pressures facing FORU’s are:

- The need to record additional data for participation in the NHFD
- IT development e.g moving to a web–based system
- Monitoring outcomes for non-hip fragility fracture inpatients
- Extension of the database to include outpatient fragility fractures

**Falls services**

Older people rarely get fractures unless they fall. An osteoporotic bone fracture is often referred to as a low-trauma fracture i.e. a fracture sustained as a result of a force equivalent to the force of a fall from standing height or less.

In 2001, the National Service Framework for Older People highlighted the need to reduce the health impact of falls. Fallers’ clinics have been defined as a “facility based either in primary or secondary health care that administers services to individuals with the purpose of preventing falls and involves qualified health professionals in the delivery of some or all of the assessment and intervention”. In 2004, NICE issued guidance on falls prevention services.

The RCP organisational audit (2009) on services for bone health and falls highlighted that there were many missed opportunities to prevent recurrent falls and fractures. Risk assessment within A&E
and fracture services could be improved and commissioning of services for prevention and management of fragility fractures was often unco-ordinated. There is a need for effective working relationships between falls services, A&E and fracture services to provide adequate assessment and intervention for those at highest risk of falls and injury.

**Specialist Osteoporosis Services**

This is a hospital clinic based service where the lead clinician may be a geriatrician, endocrinologist, rheumatologist or orthopaedic surgeon. The service usually includes a specialist nurse, DEXA scanning service and provides support and advice to other professionals for difficult cases.

**Directly Enhanced Service (DES) for Osteoporosis/Secondary prevention of Fractures Scheme**

In 2008/09, as part of the GMS contract, a general practice and their host Board have agreed arrangements for participation in the Osteoporosis/Secondary Prevention of Fractures (DES) Scheme. The target population for the DES in Northern Ireland is women who have had a fragility fracture. In the DES, the host Board must, in each financial year from 2008/09 to 2010/11, pay the general practice under its GMS contract, an Osteoporosis/Secondary Prevention of Fractures Scheme Achievement Payment, if in the reasonable opinion of the Board, the contractor has met the requirements of the DES.

The Board has to determine annually if the appropriate target has been achieved by a practice by the 31 March from 2008/09 to 2010/11. Table 2 outlines the targets practices are expected to achieve in each financial year from 2008/09 to 2010/11:

**Table 2. Key milestones in DES**

<table>
<thead>
<tr>
<th>Year</th>
<th>Target</th>
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<tbody>
<tr>
<td>1</td>
<td>A disease register of patients over the age of 50 who have had a hip or non-hip fragility fracture (the Osteoporosis/Secondary Prevention of Fractures disease register) has been compiled. One third of the patients on the contractor's Osteoporosis/Secondary Prevention of Fractures disease</td>
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<tr>
<td>register have received the appropriate assessment and treatment in accordance with the Osteoporosis/Secondary Prevention of Fractures Scheme service specification</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Two thirds of the patients on the contractor’s Osteoporosis/Secondary Prevention of Fractures disease register have received the appropriate assessment and treatment in accordance with the Osteoporosis/Secondary Prevention of Fractures Scheme service specification</td>
</tr>
<tr>
<td>3</td>
<td>All patients on the contractor’s Osteoporosis/Secondary Prevention of Fractures disease register have received the appropriate assessment and treatment in accordance with the Osteoporosis/Secondary Prevention of Fractures Scheme service specification</td>
</tr>
</tbody>
</table>
The working group completed a survey of the 5 Trusts in Northern Ireland to determine how services were organised currently, reviewed prescribing trends and local published information on outcomes of fragility fractures. The results of the survey are summarised in Table 1.

Table 1. Summary of available services by Trust area

<table>
<thead>
<tr>
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<th>BELFAST</th>
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<th>SOUTH EASTERN</th>
<th>NORTHERN</th>
<th>SOUTHERN</th>
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<td>Fracture liaison service</td>
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<tr>
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<td>ALT Yes</td>
<td>Ulster Yes</td>
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<tr>
<td>BCH No</td>
<td>Erne No</td>
<td>LVH Yes</td>
<td></td>
<td></td>
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<tr>
<td>RHT Yes MPH Yes</td>
<td>Omagh No</td>
<td>D’patrick No</td>
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<tr>
<td>Orthogeriatric service</td>
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<td>Yes, still at recruiting phase</td>
<td>Yes</td>
<td>Yes rehabilitation only</td>
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</tr>
<tr>
<td>MIH No</td>
<td>Ulster Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCH Yes</td>
<td>LVH Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RVH Yes MPH Yes</td>
<td>D’patrick No</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Falls service</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MIH Yes</td>
<td>Antrim Yes</td>
<td>CAH No</td>
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<td>Mid Ulster Yes</td>
<td>Lurgan Yes</td>
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<td>STH Yes</td>
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<td>Participate in NHFD</td>
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<tr>
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<td></td>
</tr>
<tr>
<td>BCH Yes</td>
<td></td>
<td>LVH Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RVH No</td>
<td></td>
<td>Downpatrick No</td>
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</table>
Prescribing trends

In the 5 year period between 2003/04 and 2007/08 in Northern Ireland, £29.5 million was spent on Bisphosphonates and £6.58 million on Calcium and Vitamin D. It is likely that the prescribing costs of osteoporosis drugs will increase in the next few years.
Audit of the Fractures of the Proximal Femur; Outcomes for 2002-2007

In Northern Ireland there has been a continuous audit of hip fractures treated in the Royal Victoria Hospital and Belfast City Hospital since 1997 with Altnagelvin and the Ulster Hospital joining in 2002. The audit shows that between 2002 and 2007 there was a 15% increase in the number of hip fractures from 906 in 2002 to 1037 in 2007. Between 1985 and 2007 there has been a 59% increase in hip fractures treated in Northern Ireland.

There is also significant month on month variation in fracture numbers e.g. in January 2006 there 124 fractures treated compared to 61 in April 2007.

- Females accounted for 75% of hip fractures
- Mean age for hip fractures in females was 80.3 and 73.9 in males, overall mean was 78.8 years
- Following acute fracture care, 63% were transferred for further hospital rehabilitation, 24% were discharged home, 7% returned to nursing home
- The 30 day mortality was 7.1% and 1 year mortality was 22.6% for females and 27.8% for males
- At 12 months, of the patients admitted from their own homes, 69.5% had returned home, 9.4% were in nursing homes or other institution and 19.9% had died.
- Of the 1017 admitted from a nursing home, 38% had died within one year of treatment.
Conclusions and Recommendations

Northern Ireland is facing an unprecedented increase in the number of hip fractures in the next 5-10 years. The evidence base to support prevention and management of fragility fractures highlights the need for urgent action to raise awareness of how individuals can look after their bone health and ensure early detection and treatment of osteoporosis, particularly after a low impact fracture. There is a need for collaborative working between local Investing for health partnerships, voluntary and community sectors to raise the profile of the importance of good bone health from an early age.

In Northern Ireland, many of the components of an effective fragility fracture prevention and management service are in place. There is a need for greater integration of services so that wherever you live in Northern Ireland you receive high quality prevention and management of fragility fractures.

All Trusts in Northern Ireland need to have access to:

1. A high quality fracture service supported by an orthogeriatric (acute and rehabilitation) service for those who have suffered a fragility fracture
2. A fracture liaison service for low impact fractures (for fractures treated in A&E/Minor Injury units and as in-patients)
3. Falls prevention services
4. An information infrastructure to quality assure the services being provided, monitor outcomes and compliance with national guidelines.
5. Systems to promote integration of specialist secondary care with primary care services.
Recommendations

1. A Regional Public Awareness campaign to promote good bone health should be undertaken by the Northern Ireland Public Health Agency.

2. A Fracture liaison service for secondary prevention of fragility fractures should be established in all Trusts that have A&E and Minor Injury Services to ensure secondary prevention is offered to all patients who have suffered a fragility fracture.

3. All fracture units should be supported by an acute in-patient orthogeriatric service followed by an orthogeriatric rehabilitation service.

4. An Information infrastructure to support the monitoring of care and quality of fragility fracture services should be mandatory for all fracture units. This should be achieved by enhancement of the existing IT infrastructure in fracture units. There is a need to include all fragility fractures in this, especially those treated on an out-patient basis.

5. The prevention of falls is an important part of reducing fragility fractures. There is a need to ensure effective population approaches to preventing falls and care pathways for older people needing further investigation and intervention.

6. The Directly Enhanced Service in Primary Care, to promote early detection and treatment of osteoporosis provides a major opportunity to address the impact of fragility fractures. GPs should be supported in achieving the DES requirements. It is important that this is done in partnership with secondary care.

7. The Long Term Condition Monies identified in the 2008-2011 funding cycle should be used to implement these recommendations.

8. An implementation schedule for NICE TA 160 and 161 should be developed which would include regional prescribing guidelines on initiation and maintenance of bisphosphonate therapy particularly in primary care together
with medicines management support arrangements to promote patient adherence to prescribed medicines.

9. A regional implementation group should be established to oversee the implementation of these recommendations.
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NICE. Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women. Technology Appraisal guidance 161 October 2008

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Appendix 1

Quality Improvement in the Primary and Secondary Prevention of Bone Fragility in Northern Ireland

Terms of Reference

Aim

To reduce the number of fragility fractures in NI and improve their treatment.

This will be achieved by:

1. Working with the four Investing for Health (public health) Partnerships in NI to raise awareness of maintaining good bone health in the general population.
2. Developing low impact fracture liaison services in all units that manage low impact fractures (A&E departments, minor injury units and fracture units).
3. Adherence to the standards laid down in the BOA/BGS Blue Book “The Care of Patients with Fragility Fracture”
4. Monitoring low impact fracture services through participation in appropriate national audits and databases including the national audit of falls and bone health in older people and the national hip fracture database.
5. Promoting targeted osteoporosis interventions in high risk groups e.g. nursing and residential homes, those with low impact fracture, steroids, smoking, rheumatoid arthritis, parental history of hip fracture or alcohol excess.
6. Re-designing falls services in the light of emerging evidence.
7. Considering the introduction of the FRAX fracture risk assessment tool in the management of osteoporosis.
8. Promoting effective prescribing and maximum compliance with osteoporosis medications.
9. Supporting the introduction of a DES for osteoporosis and considering the needs assessment and other information arising from the implementation of the DES.
Appendix 2: Membership of the working group

Brid Farrell (Chair)  SHSSB
Tim Beringer,  Belfast Health and Social Care Trust
Kathryn Booth  EHSSB
Janet Brennan,  Northern Health and Social Care Trust
Rachel Toland,  South Eastern Health and Social Care Trust
Lyn Donnelly,  SHSSB
James Elliott,  Belfast Health and Social Care Trust
Kevin Maguire,
Fionnuala McAndrew,  SHSSB
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