

NICEimpact

*falls and
fragility
fractures*



NICEimpact

falls and fragility fractures

Each year, almost a third of over 65s fall at least once and there are an estimated 500,000 fragility fractures. This report considers how NICE's evidence-based guidance might contribute to improvements in the prevention and management of falls and fragility fractures.

This report highlights progress made by the healthcare system in implementing NICE guidance.

We recognise that change can sometimes be challenging and may require additional resources such as training, new equipment or pathway reconfiguration.

We work with partners including NHS England, Public Health England and NHS Improvement to support these changes, and we also look for opportunities to make savings by reducing ineffective practice.



Falls prevention p4

Monthly survey data report a reduction in the proportion of people experiencing a fall while in care. This section looks at the uptake of NICE recommendations aimed at preventing falls in older people.



Detecting and managing osteoporosis and fracture risk p9

NICE has recommended the use of tools to assess fracture risk, and audit data show they are being used. For those at high risk, NICE has produced a decision support tool to help people decide if they want to take bone protection therapy. This section looks at the uptake of these medicines.



Optimal support after a fragility fracture p11

People should be followed up to support adherence to medication, but this does not always happen. As shown in this section, those that are followed up report low adherence to recommended treatment.



Spotlight on hip fracture p12

Focusing on one of the most common types of fragility fractures, this section looks at the management of people who have experienced a hip fracture.



Commentary p17

The National Osteoporosis Society highlights the impact of osteoporosis and fragility fractures on individuals and considers NICE's role in contributing to further improvements in the management of people with these conditions.

Why focus on falls and fragility fractures?

A fragility fracture is a fracture which results from a force that would not ordinarily result in a fracture, such as a fall from standing height or less.

People with osteoporosis are more likely to suffer a fragility fracture. Osteoporosis is a condition which causes bones to weaken and become more fragile.

3m

3 million people over the age of 65 fall at least once a year

This report uses national data to demonstrate how NICE recommendations are used in practice.

While data on fragility fractures and inpatient falls are provided by key national audits, data on falls prevention, particularly in the community, are lacking. However, we recognise falls prevention as a priority area, as highlighted in our quality standard on falls in older people.

NICE impact reports review how NICE recommendations for evidence-based and cost-effective care are being used in priority areas of the health and care system, helping to improve outcomes where this is needed most.

NICE provides evidence-based guidance and advice to improve health and social care services. The uptake of NICE guidance is influenced by close relationships with partners in the system, such as NHS England and Public Health England (PHE).

In 2017, member organisations of the National Falls Prevention Coordination Group, along with PHE, produced a falls and fracture [consensus statement and resource pack](#) with the aims of reducing falls and fracture risk and improving management of fracture, including secondary prevention.

Leading on from this, NHS RightCare, in collaboration with PHE and the National Osteoporosis Society, developed a [Falls and Fragility Fractures Pathway](#) which defines 3 priorities for optimisation. In this report, we have focused on what we know about the uptake and impact of our recommendations which are linked to these priorities.

NICE first published guidance on assessing the risk of fragility fractures in 2012 and this was followed by guidance on falls prevention in 2013. Quality standards for these areas have also been published. However this is a complex topic and so, in this report, we have looked at a broader range of NICE guidelines, such as multimorbidity, medicines optimisation and medicines adherence.

We routinely collect data which give us information about the uptake of our guidance. To produce this report, we have worked with national partners to select data which tell us how NICE guidance might be making a difference in priority areas of preventing and managing falls and fragility fractures. These data also highlight areas where there remains room for improvement.

Falls prevention

Since the NICE guideline on falls in older people was published, monthly survey data report a reduction in the proportion of people experiencing a fall while in care.

The proportion of trusts using inpatient fall risk prediction tools has reduced since NICE issued a recommendation that they should not be used.

NICE-recommended multifactorial risk assessments are being carried out, but vary in content.

People are being referred to NICE-recommended strength and balance training programmes, but uptake of these programmes is low.

Preventing falls requires a multifactorial approach, including targeted case finding, comprehensive assessment of risk factors and implementation of appropriate interventions.

Older people are more likely to fall. They are also more likely to suffer significant consequences, such as a loss of independence and confidence, leading to physical and mental deterioration and frailty. This increases the risk of a person experiencing multimorbidity, which is when a person has 2 or more long-term health conditions. It can also increase their risk of further falls and fractures.

In 2015/16, [NHS Improvement](#) reported that 204,269 inpatient falls were voluntarily reported by acute trusts, with a fall rate of 2.8 falls per 100 patients. However, many falls occur at home and go unreported, so the true incidence of all falls is unknown. It is estimated that [approximately 30% of people older than 65 fall at least once a year](#); this is around 3 million people in England.

The [Public Health Outcomes Framework](#) reports emergency admissions due to falls in people aged 65 or over as 2,114 per 100,000 of the population in 2016/17. The rate increases with age. This has an estimated cost to the NHS of £2.3 billion per year. Consequently, falls prevention is one of 3 priorities for optimisation highlighted in the NHS RightCare Falls and Fragility Fractures pathway.

Rates of emergency admissions due to falls in England, 2016/17

65–79 years

993 per 100,000

80+ years

5,363 per 100,000

NICE's guideline on [falls in older people](#) provides recommendations for the assessment and prevention of falls in older people aged 65 and over, both generally and when in hospital. We have national audit data on falls prevention and assessment for older people in hospital and post-fracture, but data on falls prevention in the community is limited.

A fall risk prediction tool is a tool that aims to predict a person's risk of falling. NICE recommends that fall risk prediction tools should not be used to predict inpatients' risk of falling.

Instead, all patients over 65, and those aged 50 to 64 who are judged to have a relevant underlying condition, should be considered as being at risk of falling. These people should be offered a multifactorial risk assessment to identify their risk factors for falling.

Identification of people at risk

NICE's guideline on [falls in older people](#) recommends that fall risk prediction tools should not be used to predict older people's risk of falling in hospital. These tools have not been shown to accurately predict the risk of falling. Instead, all patients over 65 should be considered at risk.

The [National Audit of Inpatient Falls](#) (NAIF) has reported a drop in the number of trusts using these tools, from 74% in 2015 to 34% in 2017. The continuing use of these tools may mean some older patients are being incorrectly assessed as lower risk, resulting in missed opportunities to implement interventions to prevent falls.

Frailty can cause falls and falls can cause or accelerate the progression of frailty. Frailty can be either physical or psychological, or a combination of the two. It typically means a person is at a higher risk of a sudden deterioration in their physical and mental health. Identifying people who may be living with frailty is a key intervention in the prevention of falls. It has also been highlighted as a key intervention area in itself, and NHS RightCare is due to publish a frailty pathway later in 2018.



A third of hospital trusts are using fall risk prediction tools, despite NICE recommending they should not be used.

Recognition of the importance of frailty is increasing. NICE has developed a [suite of resources](#) to provide practical support to Sustainability and Transformation Partnerships and Integrated Care Systems at a local level.

We have produced a [resource](#) to provide advice on how NICE guidelines and quality standards can be used to support improvements in the identification and risk reduction of people living with, or at risk of developing, frailty.

To identify people who may be living with frailty, the NICE guideline on [multimorbidity](#) recommends the use of the validated [electronic Frailty Index](#) (eFI) tool. The tool, which is built into GP electronic systems, can be used to identify people aged 65 or over who are at increased risk of future nursing home admission, hospitalisation and mortality.

Since the publication of the multimorbidity guideline, NHS England has included routine frailty identification and frailty care in the 2017/18 General Medical Services (GMS) GP contract. The supporting [guidance](#) for the contract, which refers to the NICE guideline, advises the use of an appropriate evidence-based tool such as the eFI to identify people at risk of living with moderate or severe frailty.

The contract requires that this information is coded into the health record, together with an annual medication review and falls assessments, where appropriate.

Data from the [GMS Core Contract Data Collection](#) show that, in 2017/18, 10% of people over the age of 65 were diagnosed as living with moderate or severe frailty. Of these, 10% had experienced a fall in the reporting period and 3% had been referred to a falls clinic.

Falls Risk Assessment Toolkit: a NICE-endorsed resource

The NICE Endorsement Programme formally endorses resources produced by external organisations that support the implementation of NICE guidance and the use of quality standards. An example is the [Falls Risk Assessment Toolkit](#) produced by Walsall Clinical Commissioning Group and the Centre for Medicines Optimisation at Keele University.

The toolkit runs on GP electronic records to highlight people over the age of 65 with predictors of falls risk or who are taking psychotropic medicines.

This prompts the GP to consider if the person would benefit from medication review or signposting to local falls prevention services. The ultimate aim is to decrease the number of falls and hospital admissions.

The resource has been downloaded almost 5,000 times, with download rates increasing significantly after endorsement by NICE. [Testimonials from users](#) report the tool has resulted in medicines being stopped, reducing tablet burden for people and medicines expenditure for the practice, and people experiencing a more holistic approach to healthcare.

Multifactorial falls risk assessment and interventions

A multifactorial falls risk assessment is an assessment with multiple components that aims to identify a person's risk factors for falling.

A multifactorial intervention is an intervention with multiple components that aims to address the risk factors for falling that are identified in a person's multifactorial falls risk assessment.

The NICE quality standard on [falls in older people](#) describes high-quality care in priority areas for improvement in the prevention of falls and assessment after a fall. It states there are over 400 risk factors associated with falling, and the risk of falling appears to increase with the number of risk factors.

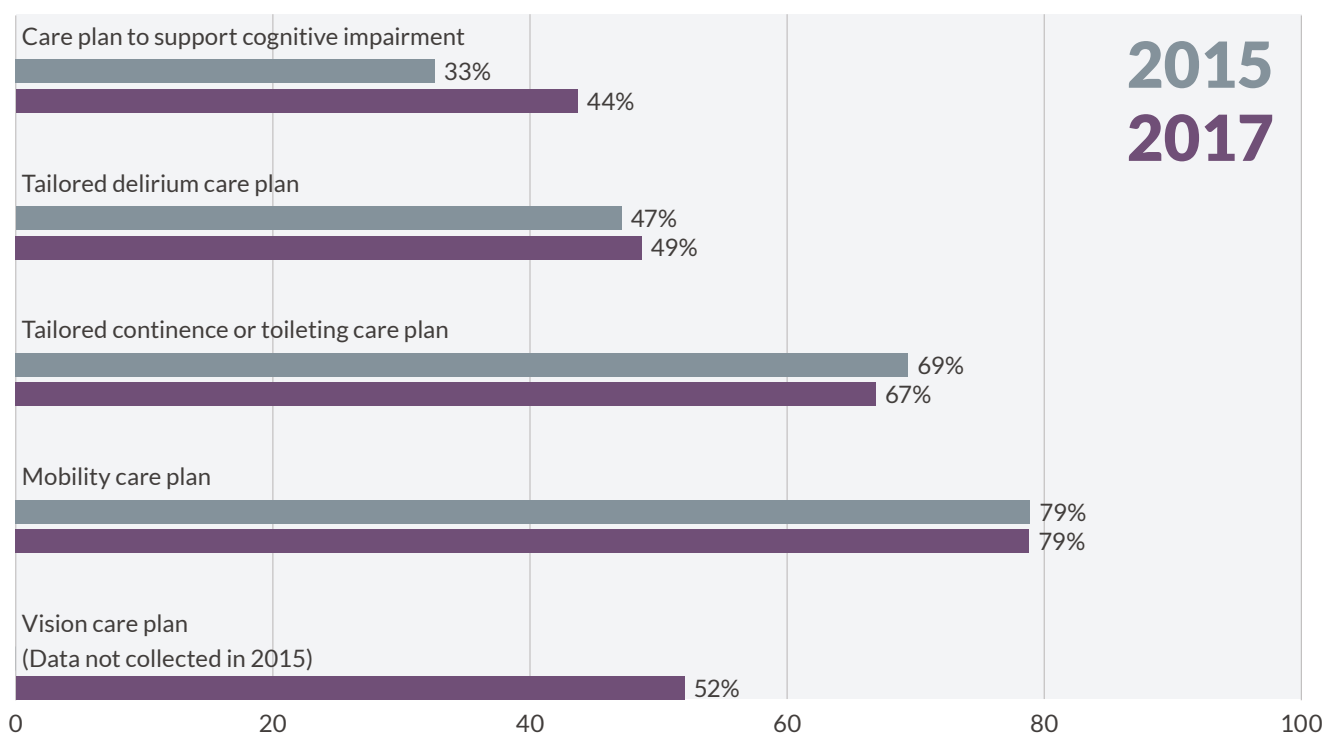
NICE recommends that older people at risk of falling are offered a multifactorial falls risk assessment. These assessments allow the implementation of person-specific interventions, designed to reduce the chances of a fall. Such interventions have been identified as a higher value intervention in the NHS RightCare pathway.

In 2015 and 2017, the NAIF measured performance against the NICE recommendation that a multifactorial falls risk assessment should be considered for all people aged 65 and over who are in hospital. They reviewed the case notes of patients admitted for non-elective reasons, for evidence that they had received a falls risk assessment and any appropriate interventions.

They found variation in the content of assessments being undertaken. Less than a fifth of patients had a record of their lying and standing blood pressure measurement, an indication of postural instability and falls risk. Fewer than half had a documented assessment of their medication and vision. For all components, there was little improvement from 2015 to 2017.

Following the assessment, interventions to address the patient's individual risk factors should be implemented. However, in many cases, patients did not have the relevant care plan documented in their notes. With the exception of cognitive impairment care plans, little improvement was shown between 2015 and 2017.

In those assessed as needing one, proportion of patients with a care plan documented in their notes



The proportion of people experiencing a fall while in care has reduced. The [Safety Thermometer](#) collects data on one day each month in participating acute trusts, nursing homes, community hospitals and in people's own homes if they are on a district nurse caseload. In this survey, participating care settings report the number of people who have experienced a fall, with or without harm, in the previous 72 hours. It shows that the proportion of people experiencing a fall resulting in harm was reported as, on average, 0.9% in 2013/14. This dropped to 0.5% by 2017/18.

The NHS RightCare pathway describes a fracture liaison service as a service which 'coordinates the identification, assessment, management and monitoring of people aged 50 years or over who have experienced a first fracture.'

Strength and balance training

NICE recommends strength and balance training programmes because these have been shown to reduce the rate of falls. The NHS RightCare pathway consider these programmes to be high-value interventions.

The [Fracture Liaison Service Database audit](#) (FLS-DB) reports on the management of people in contact with a fracture liaison service. They undertook a [facilities audit](#) in 2014 and a continuous [clinical audit](#) is collecting data on

people with fragility fractures diagnosed since the beginning of 2016. The first year of data has been published. As the audit progresses, it is expected that the number of participating services will increase and data quality will improve, resulting in a more accurate reflection of the uptake of NICE recommendations.

'I was referred for strength and balance training by my GP after I had a fall. At first, I was worried I wouldn't be able to do the exercises. But the physiotherapist was wonderful and helped me build my confidence. I also made new friends! I feel steadier on my feet and I have more confidence when walking around on my own.' Sheila, aged 72

Implementation of strength and balance training

Shared learning examples submitted by [Ashford and St Peter's Hospitals NHS Foundation Trust \(ASPH\)](#) and [Oldham Clinical Commissioning Group](#) describe how they have implemented strength and balance training programmes in their regions, as recommended by NICE.

As of February 2018, ASPH had invited 20 people following a hip fracture to attend, of which 15 completed the course. By the end of the programme, all were categorised as low risk of falls,

except 1 person who was categorised as medium risk. Follow up at 6 months has shown that whilst 4 out of 10 people had fallen again, only 2 of these were admitted to hospital.

In Oldham, they found that on average, three-quarters of those invited to attend completed the majority of the programme. At 9 months, 88.8% of participants showed improvement in the timed 'up and go' test to measure mobility, and 90.4% showed improvement in their assessment of balance and gait.

The 2014 FLS-DB facilities audit reported that, of the services which performed a falls assessment, 91% could refer people for strength and balance training if required, and 94% of these programmes were delivered by appropriately trained healthcare professionals. However, the 2016 FLS-DB clinical audit reported poor uptake of strength and balance training. Of those who were followed up, only 3% had started the training by 16 weeks post-fracture. The reasons for this poor uptake are unknown and warrant further investigation.

Detecting and managing osteoporosis and fracture risk

The majority of fracture liaison services are assessing fracture risk using NICE-recommended tools.

A group of medicines called bisphosphonates are the most commonly prescribed bone protection treatment. To help people decide whether to take this treatment, NICE has produced a decision support tool.

In a clinical audit of people aged 50 or over who had sustained a fragility fracture, less than a third of those who were recommended treatment had received it within 4 months.

500,000

500,000 people present with a fragility fracture each year

It is estimated that [3 million people in the UK have osteoporosis](#), and [over 500,000 people present with fragility fractures](#) to hospital in the UK each year, representing an estimated cost to the NHS of £4.4 billion a year.

Assessing fracture risk and consideration of preventative treatment is another priority for optimisation highlighted in the NHS RightCare pathway, which is underpinned by a [suite of NICE guidance](#).

It is important that people understand the benefits and risks of treatment and make an informed choice on starting and continuing treatment to ensure that fracture risk is reduced effectively. These key components to encourage adherence are recommended in our [medicines adherence](#) and [medicines optimisation](#) guidelines.

Methods of risk assessment

NICE's guideline on [osteoporosis: assessing the risk of fragility fracture](#) provides guidance on the selection and use of risk assessment tools in the care of adults at risk of fragility fractures.

The guideline recommends that fracture risk should be estimated using diagnostic tools such as [FRAX](#) or [QFracture](#). In the 2014 FLS-DB facilities audit, it was reported that 73% of fracture liaison services used a scoring tool such as FRAX as part of their investigation pathway.

Bone protection treatment

The NICE quality standard on [osteoporosis](#) describes high-quality care in priority areas for improvement in the management of osteoporosis. It highlights the importance of offering treatment which improves bone density and reduces fracture risk, to those at high risk of fragility fracture.

'I stumbled and fractured several bones in my hand. I was followed up by a fracture liaison service and a scan showed I had osteoporosis. It came as a massive shock. I'm now on treatment to build my bone density. I'm glad my osteoporosis was identified from a small fracture at the age of 62 rather than a much more serious one when I'm 72. I feel protected.' Jane, aged 62

In 2008, NICE recommended bisphosphonates and other treatments for the primary and secondary prevention of fragility fractures in postmenopausal women, depending on a number of risk factors. In 2017, the guidance on bisphosphonates was updated to recommend their use in the treatment of osteoporosis in both men and women, depending on their absolute fracture risk.

The FLS-DB has audited the uptake of appropriate bone protection treatment for secondary prevention of fractures. In their 2014 facilities audit, it was reported that 91% of fracture liaison services were able to recommend or prescribe bone protection therapy.

Decision support from NICE – information to help people with osteoporosis and their health professionals discuss the options

Bisphosphonates work by slowing down bone loss, which maintains bone strength and reduces risk of fractures. As with many medicines, there is a balance between the likely benefits and possible harms of taking a bisphosphonate. People may decide not to take a bisphosphonate. NICE has produced a [decision support tool](#) that helps people with

osteoporosis and their healthcare professionals discuss the options.

The tool presents evidence on the benefits of taking a bisphosphonate alongside potential adverse effects and details of how the medicine should be taken. These are all factors which may be important to a person when deciding whether to take a medicine or not.

However, in the 2016 FLS-DB clinical audit, they reported that just 23% of people aged 50 or over who had sustained a fragility fracture were recommended bone protection therapy and 11% were referred for further clinical input before a treatment recommendation was made.

Of those who were recommended treatment or were referred, only 31% had received it within 4 months of their fracture. Given the high re-fracture rate in the first 12 months post-fracture, if bone protection therapy is considered appropriate and a person chooses to take it, treatment should be started as soon as possible.

Optimal support after a fragility fracture

Over 80% of fracture liaison services who follow up their patients ask them about their adherence to medication and whether they have experienced adverse effects.

At 12 months, only 14% of people who were recommended treatment confirmed they were still taking it.

Follow-up of people to check how well they are managing their treatment means that any problems can be discussed and treatment adjusted if needed.

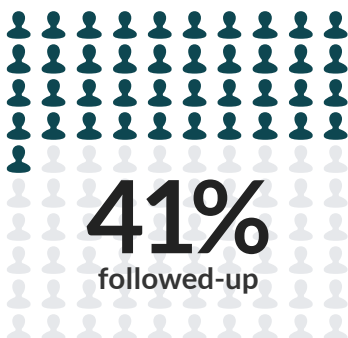
The NICE quality standard on osteoporosis reports that people sometimes stop taking their medicines due to adverse effects. NICE guidance on medicines adherence recommends that if treatment is started, the person’s experience of using the medication and their need for adherence support should be regularly reviewed. These activities form part of the optimal support after a fragility fracture which the NHS RightCare pathway includes as a priority for optimisation.

In the 2014 FLS-DB facilities audit, 82% of services who followed up patients, said they took this opportunity to ask people about adherence to their medicines and to check whether the person had experienced any adverse effects.

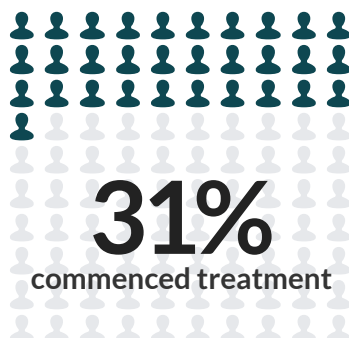
In the 2016 FLS-DB clinical audit, it was reported that, of those people who required follow up, only 41% were documented as having had follow-up by 16 weeks post-fracture, and 31% of these had commenced bone protection treatment. However, at 12 months, only 14% of people confirmed adherence to their medication.

People recommended treatment or referred for clinical input

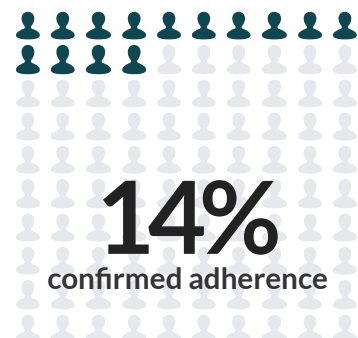
At 12–16 weeks ...



At 4 months ...



At 12 months ...



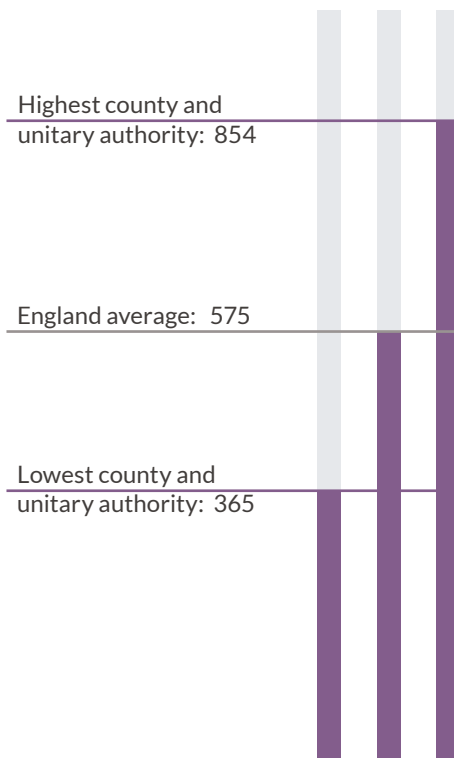
Spotlight on hip fracture

Most people who have a hip fracture are receiving NICE-recommended falls and bone health assessments.

Of those being recommended bone protection treatment, almost three-quarters were still taking the medication at 3 month follow-up.

Nearly all patients are assessed by a physiotherapist the day after surgery, although only 68% are mobilised on this day. Increased numbers of people are reporting a return to their previous level of mobility at 30 and 120 days after admission.

Age-standardised rate of emergency admissions, per 100,000 population, due to hip fracture in people 65 years or over in England, 2016/17



A hip fracture is one of the most common fragility fractures. It is a major public health issue due to an ever-increasing ageing population. The cost to the NHS is estimated to be £2 billion a year.

The NHS RightCare pathway highlights that half of hip fractures follow a previous fragility fracture. NICE has published a [suite of guidance](#) specifically on the management of hip fracture. They aim to improve care from the time people are admitted to hospital through to when they return to the community.

The [Public Health Outcomes Framework](#) reported an age-standardised rate of emergency admissions for a hip fracture in people aged 65 or over as 575 people per 100,000 in 2016/17. This rate is higher in people aged 80 or over, at 1,545 per 100,000 people. There is also wide variation across England. However, it is reassuring to see that since 2010/11, across England, there has been a reduction in the average number of emergency admissions due to hip fracture.

The [National Hip Fracture Database](#) (NHFD) reported that, in 2016, 6.7% of people had died within 30 days of presentation with a hip fracture. This has improved since 2011, when 8.5% of people were reported to have died at 30 days. They estimate up to a third of people die within a year. This is in part because many of these people have other long-term conditions or may be living with frailty, rather than the hip fracture itself.

The NHFD has been running for over 10 years and collects data from all 177 eligible hospitals in England, Wales and Northern Ireland. Data are submitted for almost all people presenting with a hip fracture. There were 65,645 people with hip fracture included in the 2016 audit. This audit is therefore a very good representation of how falls and fracture management is occurring in practice, in a vulnerable population who potentially have a lot to gain from appropriate care.

Falls assessment

In the guideline for falls in older people, NICE recommends that all older people who present for medical attention because of a fall should be offered a multifactorial falls risk assessment. Since 2010, this has also formed part of the [Best Practice Tariff for hip fracture](#).

‘I had a hip fracture after a fall at home. It was very painful and I was very nervous about walking around again after the operation. But the physiotherapists helped me get out of bed straight after surgery and came to see me every day. They helped me get my strength back and I’m now back home and doing well.’ William, aged 74

Since 2011, the number of patients with a hip fracture receiving a falls risk assessment has been consistently over 90% and in 2016, 97.8% of patients received a falls assessment prior to discharge.

The NHFD reports how many hip fractures are caused while the person was in hospital. This can generally be viewed as an indicator of inpatient falls that lead to hip fracture, although it is possible that a small proportion of these hip fractures are due to an underlying pathological disorder, rather than a fall.

In 2013, it was reported that nearly 5% of hip fractures occurred while in hospital. Reassuringly, this figure dropped to 3.9% in 2015. However, in 2016, this figure had risen slightly to 4.1%, so it is important that trusts continue to maintain measures aimed at preventing inpatient falls.

Bone protection treatment

The NICE guideline on osteoporosis recommends that everyone who has experienced a fragility fracture should be assessed for fracture risk. The need for bone protection treatment should be considered for those people who reach an intervention threshold. An assessment for bone protection treatment is also included in the Best Practice Tariff for hip fracture.

The NHFD reported that the proportion of patients receiving bone health assessments is usually very high; above 90% since 2012, and almost 97% of patients were reported to have received this assessment in 2016.

However, while the number of assessments is increasing, the number of people being recommended bone protection treatment is not increasing. Instead, treatment is being assessed as being inappropriate for more people, from 14.2% of those assessed in 2012, to 21.6% in 2016.

98%

98% of people admitted with a hip fracture receive a falls assessment before discharge

The reasons why treatment may not be appropriate are not captured, but the NHFD is seeking to understand why some trusts have higher proportions of patients not receiving treatment than others.

Of those who do receive treatment, the latest NHFD audit reported that, at 3 month follow-up, 74% were still taking appropriate medication. Of the remaining people, it was reported that 13% had stopped taking their medication and a further 13% were recorded as unknown.

It is likely that some of those recorded as unknown had also stopped taking their medication. This emphasises the importance of follow-up to support people taking medication, as recommended in our guideline on medicines adherence.

Physiotherapy

The NICE guideline for [hip fracture management](#) makes recommendations which emphasise the importance of coordinating care through a multidisciplinary hip fracture programme to help people recover faster and regain their mobility.

Early rehabilitation after hip fracture surgery can reduce length of hospital stay and avoid the complications of prolonged bed confinement, including reduced independence and frailty. NICE recommends that, if possible, daily mobilisation starting the day after surgery is undertaken.

68%

68% of people admitted with a hip fracture were mobilised the day after surgery

Introducing therapy champions to improve the 24 hours approach to patient rehabilitation

To help meet the NICE recommendation of daily mobilisation, Mid Cheshire Hospitals Foundation Trust introduced [therapy champions](#), healthcare assistants who had undertaken additional training in therapy competency, to allow them to contribute to the rehabilitation process, 24 hours a day, 7 days

a week. This freed up the physiotherapists to handle more complex cases and allowed patients to work towards their rehabilitation goals throughout the day.

The trust reported positive results for both length of stay and falls reduction, as well as increased satisfaction from both patients and staff.

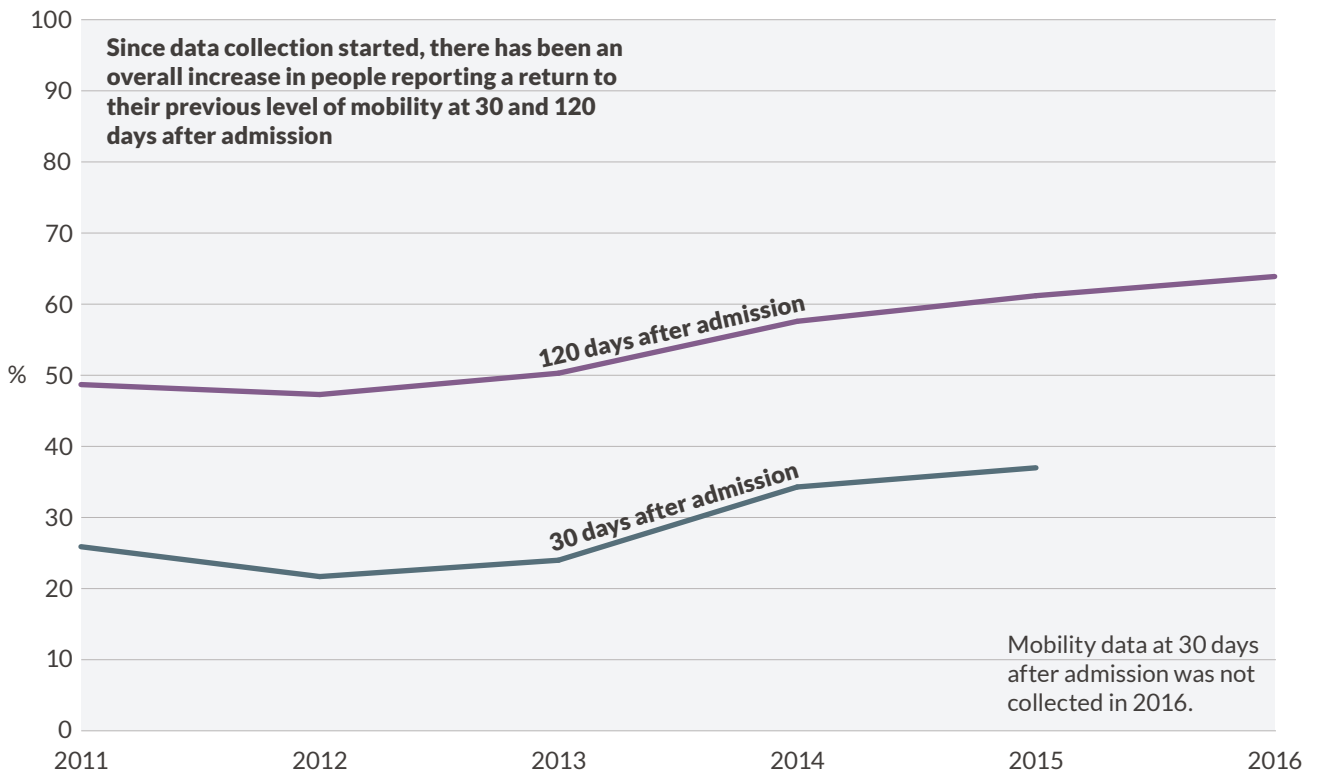
The [Physiotherapy Hip Fracture Sprint Audit](#) (PHFSA) on physiotherapy services after hip fracture reported that, in 2017, while 98% of patients were assessed the day after surgery, only 68% of patients were able to be mobilised on that day. The reasons given for this included factors such as pain

control issues and inadequate equipment, which if addressed, could potentially result in more patients being mobilised earlier.

In line with our recommendations, daily mobilisation comprised a large component of therapy given in the first week. However, it was also reported that only 39% of services were able to provide physiotherapist-led rehabilitation 7 days a week until patients had reached their goals.

Despite these challenges, it is reassuring to see that the NHFD have reported that over two-thirds of people have returned to their original residence by 120 days after their hip fracture. In addition, the [NHS Outcomes Framework](#) has reported an overall improvement in people reporting a return to their previous level of mobility or walking ability at 30 and 120 days after admission for a hip fracture.

Proportion of people reporting a return to their previous level of mobility after admission for a hip fracture



If a patient has not yet reached their rehabilitation goals but is otherwise suitable for discharge, NICE recommends that consideration should be given to continuing rehabilitation in the community. In particular, NICE makes a recommendation that people from care or nursing homes should not be excluded from such programmes.



The PHFSA reported that 88.2% of physiotherapy services say they are able to provide such services to people in care and nursing homes. However, there are no data on how many people in these circumstances actually receive continued rehabilitation after discharge.

One in ten services reported that they could not provide community rehabilitation programmes to people admitted from care homes, who return to their original place of residence after discharge. These people are likely to be those living with either moderate or severe frailty, who may benefit most from the therapy.

Provision of intermediate care can bridge the gap between hospital admission and returning home. It may be an option for older people who have suffered a hip fracture. NICE's guideline on [intermediate care including reablement](#) defines intermediate care as a multidisciplinary service that helps people to be as independent as possible. It recommends that the intermediate care team includes a broad range of disciplines, including physiotherapists.

The [National Audit of Intermediate Care](#) aims to understand how intermediate care services have developed nationally and provides key data on community rehabilitation generally. For example, in the 2017 report, they have shown that service users of all ages can benefit from intermediate care. While this audit does not specifically focus on people who have experienced a hip fracture, it does provide an insight into a service which could prove beneficial to this group of people.

Commentary

Fizz Thompson, June 2018



Fizz Thompson is the Clinical Director for the National Osteoporosis Society.

This impact report highlights the importance of fragility fractures and osteoporosis. Over 3 million people in the UK are estimated to have osteoporosis and around 500,000 fragility fractures are estimated to occur each year. 1 in 2 women and 1 in 5 men over the age of 50 are expected to break a bone during their lifetime as a result of osteoporosis.

For over 10 years, NICE has developed a range of resources to support clinical decisions for people with osteoporosis. The suite of guidance produced by NICE highlights the importance of, and underpins the assessment of, fracture risk and consideration of preventative treatment. As the only UK charity for people with osteoporosis, the National Osteoporosis Society (NOS) has, in partnership with PHE and NHS RightCare, developed an optimal pathway for falls and fragility fractures, which highlights the importance of aligning falls and fractures as an integrated pathway. This report shows the extent of progress in implementing NICE recommendations which are linked to the priorities in the pathway.



Identifying patients in a systematic way could prevent up to a quarter of all hip fractures: this is almost 20,000 hip fractures a year.

A NOS survey demonstrated that one-fifth of women with a broken bone have broken 3 or more before being diagnosed. 1 in 4 people of working age diagnosed with osteoporosis have had to give up work, change their job or reduce their hours.

Approximately half of all hip fractures follow a previous fragility fracture. By identifying patients in a consistent, systematic way, it is estimated that up to 25% of hip fractures (about 20,000 a year) could be prevented. When accounting for the demographic projections for 2025, the number of hip fractures are projected to rise to 682,000.

To achieve the better outcomes we should expect from putting NICE recommendations into practice, the NOS has championed the evidence-based Fracture Liaison Service (FLS) as a model of service delivery. This NICE impact report highlights some of the successes of FLSs, such as the large number that can now refer relevant patients to strength

and balance training programmes. This NICE recommended intervention, prioritised in the NHS RightCare pathway and the NOS FLS standards, has been shown to reduce people's fear of falling and improve patient confidence.

Other evidence demonstrates that FLSs improve the rate of patients having their bone mineral density measured, and starting and adhering to treatment, by 20%.

Bone health assessment and falls prevention all have a role to play in the prevention of fragility fractures, reducing the likelihood of long-term societal and personal impact they can lead to. It is good to see that these are being achieved in a vulnerable population as shown in the National Hip Fracture Database. We look forward to these successes being demonstrated more widely across people with other fragility fractures.



NICE has a vital role in ensuring all patients have access to treatment. The National Osteoporosis Society continues to work towards reducing inequalities in the provision of services.

Understanding ageing well and supporting people in older age living with frailty is focused upon in NICE guidance. The introduction of frailty tools such as the electronic frailty index will be used to identify those at increased risk of fractures and falls.

Still, there is room for improvement. Whilst the audit data show that people are being referred for strength and balance training if they need it, uptake of these programmes is low. NOS is addressing the importance of physical activity to support NICE recommendations. NOS has undertaken work to understand the reasons for low uptake and to add to the evidence to remove the barriers which are preventing people from attending and completing these programmes.

Despite NICE guidance and quality standards, there continues to be inequity in the treatment of osteoporosis and the provision of FLSs nationally. At the NOS, we continue to work towards reducing these inequalities.

NICE has a vital role in ensuring that all patients have access to the most clinically- and cost-effective treatments. By putting patients at the heart of what they do, NICE continues to support professionals to make a positive impact on the prevention and management of fractures, falls and frailty.

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