

The 10 Year Health Plan for England – Royal Osteoporosis Society consultation response

Q1: What does your organisation want to see included in the 10-Year Health Plan and why?

Osteoporosis affects 3.5 million people in the UK and causes over half a million broken bones every year.¹ Half of women over 50 will suffer fractures because of the condition, and a fifth of men.² These fractures are often life-changing, with hip fractures carrying a 28% mortality rate within a year.³ Despite its prevalence, osteoporosis is under-recognised and under-funded within the NHS, resulting in systematic missed opportunities to prevent life-changing and costly fractures. This is against a backdrop of an ageing population and a predicted increase in fractures of 25-30% by 2034.⁴

Meanwhile, recent analysis by Lane Clark & Peacock (LCP) reveals the significant economic burden of osteoporotic fractures on working-age people. More than 57,000 fractures occur annually among employed individuals in England, leading to over 1.5 million sick days and informal care absences each year, a direct cost to employers of over £129 million.⁵

The Royal Osteoporosis Society (ROS) welcomes the opportunity to contribute to the 10-Year Health Plan. We advocate a comprehensive, strategic approach to osteoporosis that prevents fractures, reduces NHS and social care costs, and improves quality of life for millions.

1. Universal Fracture Liaison Services

The ROS celebrates the Government's commitment to provide 100% Fracture Liaison Service (FLS) coverage by 2030 - a landmark policy change for people with osteoporosis. FLS is recognised as the gold standard for secondary fracture prevention, systematically identifying and supporting individuals following a

¹ International Osteoporosis Foundation. Osteoporosis in Europe: burden, management, and opportunities. 2018. Available at: https://www.osteoporosis.foundation/sites/iofbonehealth/files/2019-06/7.%202018_EU6UK_Slidekit_English.pdf.

² Borgström F, Karlsson L, Orsäter G, et al. Fragility fractures in Europe: burden, management and opportunities. *Arch Osteoporos*. 2020;15(1):59.

³ Baji P, Patel R, Judge A, Johansen A, Griffin J, Chesser T, Griffin XL, Javaid MK, Barbosa EC, Ben-Shlomo Y, Marques EMR, Gregson CL; REDUCE Study Group. Organisational factors associated with hospital costs and patient mortality in the 365 days following hip fracture in England and Wales (REDUCE): a record-linkage cohort study. *Lancet Healthy Longev*. 2023 Aug;4(8):e386-e398. doi: 10.1016/S2666-7568(23)00086-7.

⁴ Kanis JA, Norton N, Harvey NC, Jacobson T, Johansson H, Lorentzon M, McCloskey EV, Willers C, Borgström F. SCOPE 2021: a new scorecard for osteoporosis in Europe. *Arch Osteoporos*. 2021 Jun 2;16(1):82. doi: 10.1007/s11657-020-00871-9. PMID: 34080059; PMCID: PMC8172408.

⁵ Lane Clark & Peacock analysis available on request

fragility fracture and reducing the risk of re-fracture by up to 40%.⁶ FLS services break even in 18-24 months and have a ROI of £1.88 for every £1 invested. This ROI includes medication and prescription costs. However, to achieve this commitment, a period of pump-priming funding will be necessary. ROS data scrutinised by DHSC analysts shows that universal FLS will prevent approximately 74,000 fractures, including 31,000 hip fractures, over five years - saving the NHS £440m million and freeing up 750,000 hospital bed days. The introduction of AI technologies will further improve the efficiency and effectiveness of FLSs by rapidly identifying high fracture risk patients from existing NHS data.

2. Overturning long-term under-prioritisation of bone health

In terms of years lost to premature mortality and disability (DALYs), fragility fractures are the fourth most consequential medical condition and second highest causes of emergency bed day stay.⁷⁸ Yet, osteoporosis is characterised by under-diagnosis; undertreatment; and low public and clinical awareness.

Osteoporosis does not currently receive the same recognition or resourcing by the NHS as a long-term condition. Osteoporosis must be given parity with other long-term conditions, and defined as such within the NHS, to allow enhanced and equitable care and management.

To overcome the fragmentation of care, the ROS proposes the establishment of a National Clinical Director or National Specialty Adviser (working under the NCD for MSK conditions) for Fracture Prevention and Osteoporosis within NHS England. Further detail in question two.

3. Case-finding

61% of the people who need a bone health assessment because they have one of the three major risk factors for osteoporosis are falling through the cracks and remaining undiagnosed until they have already suffered multiple fractures.⁹ The late diagnosis that comes as a result of these delays means two-thirds of people at high risk of broken bones are missing out on life-changing – and in the case of broken hips – life-saving drugs.

Systematic case-finding in primary care settings is an accessible and pragmatic solution to fracture prevention. While examples of this approach exist in some areas, it has not been adopted across the country. Simple data searches within

⁶ Nakayama A, Major G, Holliday E, et al. Evidence of effectiveness of a fracture liaison service to reduce the re-fracture rate. *Osteoporosis Int* 2016;27:873–9

⁷ Borgström, F., Karlsson, L., Ortsäter, G. et al. Fragility fractures in Europe: burden, management and opportunities. *Arch Osteoporos* 15, 59. 2020.

⁸ Hospital Episode Statistics. *Hospital Admitted Patient Care Activity, 2022-23*. NHS Digital. Available from: <https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2022-23>

⁹ Pradhan A, Nicholls E, Welsh V, Paskins Z. IN PREPARATION Bone Health Assessment in men and women with risk factors for fragility fractures. 2022.

GP practices can identify patients already known to have osteoporosis or those at high risk of fractures. Further detail in question two.

4. Improving treatment adherence

Treatment adherence is essential for reducing fracture risk, yet 80% of people who are recommended osteoporosis medication never start taking it, or stop taking it within a year. Community and clinical (practice-based) pharmacists are ideally positioned to play a pivotal role in monitoring adherence. The New Medicine Service (NMS) is a welcome initiative that supports patients who have been newly prescribed osteoporosis medication. However, its narrow eligibility criteria mean that not all patients benefit.

The current funding offered through the Quality and Outcomes Framework (QOF) for GP practices holding a register of osteoporosis patients is not fit for purpose. It only focuses on secondary prevention, lacks quality measures, and does not incentivise monitoring. Incentives equitable with other conditions are not only important for the identification of osteoporosis but also for monitoring and follow up to address the issue of poor adherence

5. NHS Health Check

Access to DXA scanning, the 'gold standard' test to measure bone mineral density, remains limited and patchy. The UK has one of the lowest numbers of DXA scanners per head of population in Europe, ranking 23rd out of 29 countries.¹⁰ DXA is a very important component of osteoporosis assessment and diagnosis but should always be interpreted in conjunction with an individual's risk factor profile.

In many cases, the need for treatment can be established from the risk factors alone without the need for DXA. Simple questions relating to previous fractures after a fall as an adult, previous oral steroid use for more than three months, and a parent having had a hip fracture after a fall could facilitate diagnosis. The ROS recommends including these - or similar - questions within the NHS Health Check for 40–74-year-olds. This age group (and those above it) is at high risk of fracture and could be diagnosed and treated through the routine health check.

Inclusion of key questions in the NHS check has the potential for timely identification of people who'd benefit from preventative measures (such as lifestyle/HRT) and others who would benefit from more detailed assessment.

¹⁰ All-Party Parliamentary Group on Osteoporosis and Bone Health. Review of DXA (Bone Density Scanning) Facilities. Royal Osteoporosis Society. Available from: <https://strwebprdmedia.blob.core.windows.net/media/4q3jpfv3/final-dxa-report-13-12-23.pdf>

Q2: What does your organisation see as the biggest challenges and enablers to moving more care from hospitals to communities?

Osteoporosis is too often unnecessarily treated in secondary care; after fractures that follow many missed opportunities to diagnose and treat the condition earlier. Moving care into the community is essential to ensure osteoporosis is managed proactively, rather than reactively.

Challenges

1. Low clinical awareness of osteoporosis

Osteoporosis remains under-recognised and poorly understood among healthcare professionals. The lack of dedicated leadership or recognition as a long-term condition within the NHS contributes to this. Without improved understanding and prioritisation, osteoporosis often fails to be diagnosed or treated even after a fracture occurs, which shifts care from primary to secondary settings. For instance, the ROS is routinely contacted by people with vertebral (spinal) fractures that were missed by GPs. Up to 70-80% of vertebral fractures can be undiagnosed.¹¹¹² Stephen Robinson, an ROS member, is one such case. After initially presenting at his GP with back pain at age 64, he suffered a further 10 fractures in six months before obtaining a diagnosis through a private clinic. Stephen was forced out of work by the pain, when he would have wished to work for longer.

Patients like Stephen rely on primary care professionals to consider a fracture when they present with back pain that could be related to osteoporosis. They need their GP to refer them for imaging promptly, diagnose and treat the underlying osteoporosis, and prevent further fractures. Healthcare professionals have previously described to the All-Party Parliamentary Group (APPG) on Osteoporosis and Bone Health how little training they receive on osteoporosis and how they rely on the support of specialist services to advise their patients better.¹³

2. Limited case-finding and screening

Currently, 61% of individuals with one of the three major risk factors for osteoporosis do not receive a bone health assessment.¹⁴ A lack of systematic case-finding in primary care means many patients remain undiagnosed until they have suffered avoidable, debilitating fractures. The late diagnosis that comes because of these delays means two-thirds of people at high risk of broken bones

¹¹ Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women (TA161). NICE: 2008. Available from: <https://www.nice.org.uk/guidance/ta161>.

¹² Cooper C, Atkinson EJ, O'Fallen WM, Melton LJ 3rd. Incidence of clinically diagnosed vertebral fractures: a population-based study in Rochester, Minnesota. *J Bone Miner Res.* 1992;7:221-7.

¹³ All-Party Parliamentary Group on Osteoporosis and Bone Health. Inquiry report into primary care. 2022 Dec. Available at: <https://strwebprdmedia.blob.core.windows.net/media/mfq13b50/appg-on-osteoporosis-and-bone-health-inquiry-report-into-primary-care-2022.pdf>.

¹⁴ Pradhan A, Nicholls E, Welsh V, Paskins Z. IN PREPARATION Bone Health Assessment in men and women with risk factors for fragility fractures. 2022

are missing out on life-changing - and, in the case of broken hips, life-saving - drugs. Broken hips are heart-attack level events, with more than a quarter of people who break a hip dying within a year.

3. Insufficient diagnostic capacity outside hospitals

Access to DXA scanning is severely limited. The number of DXA scanners per head of population in the UK is one of the lowest in Europe, ranking 23rd out of 29 countries.¹⁵ Long waiting lists delay access to treatment for people at high risk of fracture, particularly in areas with high health inequalities, where waiting times have worsened since the COVID-19 pandemic. To manage backlogs, some services have resorted to sending uninterpreted scan images to referring clinicians. This compromises patient care, as it means GPs are unable to make informed decisions about care.¹⁶

4. Workforce capacity for diagnosis

There is a significant lack of trained DXA operators, osteoporosis specialists, and care coordinators in community settings. The chronic de-prioritisation of bone health has resulted in insufficient workforce capacity to meet demand. There is only one accredited DXA reporting training provider in the UK – and there have been significant gaps in provision with no courses running between 2022 and 2024. Moreover, roles within DXA and FLS that could attract individuals seeking flexible working have remained unsupported, further limiting diagnostic capacity.¹⁷

5. Challenges in community pharmacy engagement

Community pharmacists have the potential to play a key role in osteoporosis care through improved identification before and after a fracture and care optimisation including lifestyle and medications. However, many pharmacists have expressed frustration at the limitations placed on their ability to support patients, particularly as their expertise could be effectively used in monitoring treatment and improving adherence. Additionally, clinical pharmacists face time constraints, often splitting their time across various conditions, limiting their capacity to provide in-depth support for osteoporosis patients. Pharmacists also require specific training to effectively contribute to shared decision-making, but such training opportunities remain scarce.¹⁸

6. Inadequate monitoring of osteoporosis patients

¹⁵ All-Party Parliamentary Group on Osteoporosis and Bone Health. Review of DXA (bone density scanning) facilities. 2023 Dec. Available at: <https://strwebprdmedia.blob.core.windows.net/media/4q3jpfv3/final-dxa-report-13-12-23.pdf>.

¹⁶ Ibid

¹⁷ Ibid

¹⁸ All-Party Parliamentary Group on Osteoporosis and Bone Health. Inquiry report into primary care. 2022 Dec. Available at: <https://strwebprdmedia.blob.core.windows.net/media/mfq13b50/appg-on-osteoporosis-and-bone-health-inquiry-report-into-primary-care-2022.pdf>.

The current funding offered through the Quality and Outcomes Framework (QOF) for practices holding a register of osteoporosis patients is not fit for purpose and this is a key missed opportunity. It only focuses on secondary prevention, lacks quality measures, and does not incentivise monitoring.

For comparison, GPs receive significantly more funding through QOF for managing other chronic conditions of comparable prevalence such as diabetes. In 2023 for example, GP practices received three QOF points - equivalent to around £622.58 annually - for maintaining a register of osteoporosis patients, whereas managing diabetes could yield up to £14,000 annually per practice.¹⁹ Practices qualify for osteoporosis-related funding even if their registers are incomplete and patients are not receiving appropriate treatment, leading to inadequate care. Incentives are not only important for the identification of osteoporosis but also for monitoring and follow up to address the issue of poor adherence with resulting fracture prevention leading to a substantial return on investment.

Enablers

1. Leadership and long-term condition recognition

Recognising osteoporosis as a long-term condition would raise understanding of osteoporosis among clinicians, drive improvements in care, and begin to address the burden fragility fractures place on the health service. Embedding osteoporosis into routine long-term condition management would allow for proactive assessments and treatment, reducing the incidence of debilitating fractures. Healthcare professionals, including GPs and nurses, have told the APPG on Osteoporosis and Bone Health that incorporating osteoporosis into regular long-term condition reviews is not overly burdensome and could help integrate fracture prevention into standard care practices. Establishing osteoporosis as a long-term condition would ensure it receives the attention it requires within healthcare pathways, integrating assessments into routine care and reducing the burden of fragility fractures on the NHS.

Establishing a National Clinical Director or National Specialty Adviser for Fracture Prevention and Osteoporosis within NHS England would provide much-needed leadership. This leadership is essential to drive the recognition of osteoporosis as a long-term condition, ensuring it is embedded into routine long-term condition management within healthcare pathways. This role would address the current lack of 'ownership' of osteoporosis, cut across historical boundaries between specialties, and be responsible for the standardisation of high-quality fracture prevention and osteoporosis services. At present, the quality of osteoporosis services is too dependent on local champions and does not reflect local patient need. The role could support the establishment of regional clinical networks, building on the draft specification already developed through the Best MSK

¹⁹ NHS England. Quality and Outcomes Framework guidance for 2023/24. 2024 Jan. Available at: <https://www.england.nhs.uk/long-read/quality-and-outcomes-framework-guidance-for-2023-24/>

programme By embedding leadership at all levels of health infrastructure through the establishment of clinical networks, it would help raise understanding among healthcare professionals, drive equitable funding, and ensure that osteoporosis is prioritised in primary care settings. Having a national figure representing osteoporosis care would promote and facilitate the development of universally applicable and quality-assured fracture prevention services.

2. Systematic case-finding and screening

Systematic case-finding in primary care is essential for early identification and intervention in osteoporosis. This involves conducting data searches within GP practices to identify patients already known to have osteoporosis or those at high risk of fractures with key risk factors that warrant detailed assessment, such as individuals over 75 or those with vertebral fractures. Case-finding aims to restore patients who are known to be at risk to follow-up and ensure they receive appropriate management.

The use of fracture risk assessment tools is also crucial in this process. Fracture risk assessment tools can estimate a patient's probability of sustaining a fracture, and integrating these tools directly into GP IT systems would streamline assessments, allowing healthcare professionals to quickly identify individuals at risk. Currently, GPs must manually input data into fracture risk assessment tools, which is time-consuming and can discourage usage. Embedding assessment tools into clinical systems would allow for auto-population of patient data, making the process more efficient and reducing barriers to use.

Additionally, automated alerts within electronic health records can prompt GPs to assess patients with risk factors for osteoporosis, such as those who have experienced low-trauma fragility fractures. These alerts can help increase adherence to clinical guidelines, ensuring that patients receive timely bone density testing and osteoporosis treatments. Data sharing between secondary and primary care can further facilitate case-finding by triggering alerts when a patient has suffered a fracture, prompting primary care to initiate further investigations and treatment.

A targeted screening programme could also be developed to identify those at high fracture risk, reducing the burden on secondary care. Screening efforts can complement systematic case-finding, particularly for patients who may not have obvious risk factors. Early research shows that such an initiative would be both clinically effective and cost-efficient. The UK primary care-based MRC-SCOOP (Screening for Osteoporosis in Older People) Trial examined a systematic approach to identifying older women for fracture prevention. The intervention led to a 28% reduction in hip fracture risk and was found to be cost-saving (reducing cost by £286 per patient). The data indicate that

at least 8000 hip fractures could be prevented annually, resulting in a huge reduction in the burden on our hard-pressed NHS. The intervention also increased adherence to treatment.^{20,21,22,23,24}

3. Expanding diagnostic capacity through CDCs and WHHs

Expanding DXA scanning capacity through Community Diagnostic Centres (CDCs) and integrating osteoporosis care within Women's Health Hubs (WHHs) would support the transition from hospitals to the community. In January 2024, there were only 15 Community Diagnostic Centres (11% of total centres at the time) providing DXA.²⁵ Including osteoporosis assessments in the core specification of WHHs would ensure that more patients receive timely and accurate diagnoses in community settings. Increasing DXA capacity is particularly crucial given the findings from the recent review by the APPG on Osteoporosis and Bone Health, which highlighted that the UK has one of the lowest numbers of scanners per head of population in Europe.²⁶

4. Upskilling and expanding the workforce

Increasing workforce capacity through a robust system of training for DXA operators, as recommended by the Richards Review, would be a crucial step toward addressing current gaps. NHS England and the Department for Health and Social Care must establish a training academy for DXA practitioners to overcome the reliance on voluntary sector providers. Upskilling general physiotherapists and pharmacists would also enable more effective community management of osteoporosis.

Physiotherapy plays an essential role in managing recovery after hip or vertebral fractures and in preventing falls, which are a key risk factor for fractures. Upskilling general physiotherapists to provide specialised osteoporosis care would ensure better patient outcomes. Additionally, retaining skilled staff within the NHS by offering flexible working options in roles such as DXA and FLS would enhance community capacity and ensure continuity of care.

²⁰ Shepstone L, Fordham R, Lenaghan E, et al. A pragmatic randomised controlled trial of the effectiveness and cost-effectiveness of screening older women for the prevention of fractures: rationale, design and methods for the SCOOP study. *Osteoporos Int.* 2012;23:2507–15.

²¹ Shepstone L, Lenaghan E, Cooper C, Clarke S, Fong-Soe-Khioe R, Fordham R, et al. Screening in the community to reduce fractures in older women (SCOOP): a randomised controlled trial. *The Lancet.* 2018 Feb 24;391(10122):741–7.

²² McCloskey E, Johansson H, Harvey NC. Management of patients with high baseline hip fracture risk by FRAX reduces hip fractures—a post hoc analysis of the SCOOP study. *J Bone Miner Res.* 2018;33:1020–6.

²³ Turner DA, Khioe RFS, Shepstone L, et al. The cost-effectiveness of screening in the community to reduce osteoporotic fractures in older women in the UK: Economic Evaluation of the SCOOP Study. *J Bone Miner Res.* 2018;33:845–51.

²⁴ Parsons CM, Harvey N, Shepstone L, Kanis JA, Lenaghan E, Clarke S, et al. Systematic screening using FRAX® leads to increased use of, and adherence to, anti-osteoporosis medications: an analysis of the UK SCOOP trial. *Osteoporosis International.* 2020 Jan 1;31(1):67–75.

²⁵ Smyth K. Written question UIN 17949: Osteoporosis: Screening. 2024 Mar 11. Available at: <https://questions-statements.parliament.uk/written-questions/detail/2024-03-11/17949/>

²⁶ All-Party Parliamentary Group on Osteoporosis and Bone Health. Review of DXA (bone density scanning) facilities. 2023 Dec. Available at: <https://strwebprdmedia.blob.core.windows.net/media/4q3jpfv3/final-dxa-report-13-12-23.pdf>.

5. Leveraging community pharmacists

Community pharmacists are ideally positioned to support osteoporosis management through shared decision-making support and monitoring treatment adherence. Training opportunities must be expanded to upskill pharmacists in shared decision-making and osteoporosis management, ensuring they are equipped to provide comprehensive support to patients. This approach has already proven effective in some areas, such as the Northern Bone Health Programme, where case-finding was undertaken centrally by clinical pharmacists.²⁷

6. Enhanced incentives through QOF

Modified and substantially increased incentives within the QOF could encourage more effective monitoring of osteoporosis patients in primary care. By aligning the funding structure for osteoporosis care with other long-term conditions, such as diabetes, healthcare professionals would be better incentivised to proactively manage patients. This should include rewarding not only the maintenance of patient registers but also the quality of case-finding, provision of appropriate treatments, monitoring for adherence and long-term review. Such changes would support proactive management, improving the quality of care for osteoporosis patients and reducing the risk of future fractures.

²⁷ Rees J, Dunne S. Evaluation of the Northern Bone Health Programme. 2021. Available at: <https://bonehealth.thenhsa.co.uk/evaluation/>

Q3: What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

Challenges

1. Lack of integration of bone assessment tools

A significant challenge in osteoporosis care is the lack of integration of fracture risk assessment tools into general practice IT systems. Currently, GPs are required to log into separate systems to manually input data for fracture risk assessment, which is time-consuming and discourages use. This lack of integration means that primary care clinicians often miss opportunities to identify patients at risk of fractures, ultimately leading to delayed diagnoses and a reactive approach to care.

Current infrastructure also lacks the ability to efficiently code and track patients with osteoporosis or those at high risk of fractures. Several clinicians told the APPG on Osteoporosis and Bone Health that their IT systems are not capable of integrating fracture risk factors as smoothly as they do for other conditions, such as diabetes. As a result, case-finding efforts become cumbersome, and patients who need assessment and treatment are often missed. Inconsistent coding and poor data entry further complicate the situation, making it difficult for healthcare professionals to follow up on patients effectively.

2. Fragmented IT systems and data sharing

The fragmentation of IT systems between primary and secondary care is another significant challenge. Many healthcare professionals lack access to patient notes from secondary care, often relying on hospital letters that take months to arrive or do not arrive at all. The lack of shared patient records impedes coordinated care for osteoporosis patients. Moreover, only 20% of NHS organisations are digitally mature, and only a small number of Integrated Care Systems have achieved shared patient records to date.²⁸ Without unified and efficient data-sharing mechanisms, essential information about patient history, fractures, and treatments may be lost or delayed.

3. Opportunities for enhancing digital tools in Fracture Liaison Services

There is a significant opportunity to enhance the use of digital tools in supporting FLS. Many FLSs could benefit from improved hospital electronic record (EPR) systems that meet their specific needs, which would lead to better use of staff time, improved patient outcomes, and secure data management. By ensuring EPR systems meet the basic requirements for FLS assessment and patient management, including data exports to NHS mandatory clinical audits, we can unlock the full potential of technology to optimise the flow of patients and the

²⁸ Department of Health and Social Care. A plan for digital health and social care. 2022 Jun. Available at: <https://www.gov.uk/government/publications/a-plan-for-digital-health-and-social-care/a-plan-for-digital-health-and-social-care>.

overall effectiveness of the services. AI models are being used to rapidly identify thousands of patients with spine fractures on existing radiology images that have not been acted on and so these patient remain undiagnosed. Embracing these digital opportunities will support more efficient care pathways and improve the experiences of both patients and healthcare staff.

Enablers

1. Integrating bone assessment tools into primary care IT systems

The integration of fracture risk assessment tools into primary care IT systems would greatly enhance osteoporosis management by allowing healthcare professionals to more efficiently assess a patient's fracture risk. Such tools could be embedded within existing systems, allowing patient data to be auto-populated and continuously updated based on clinical changes, such as weight, fractures, or prescriptions. This seamless integration would significantly reduce the time burden on primary care staff and ensure that patients at risk of osteoporosis are identified and managed in a timely manner.

Additionally, implementing automated alerts within electronic health records to prompt GPs to assess patients with risk factors, such as previous fractures, would be instrumental in ensuring early intervention. Data sharing between acute and primary care can further support these alerts, ensuring that when, for example, a patient is diagnosed in secondary care with a condition associated with osteoporosis (for example, inflammatory arthritis), it prompts timely assessment and management of their fracture risk by their GP.

2. Digital FLS

The development of digital FLS systems can support more efficient and scalable osteoporosis care. Implementing mandatory contractual requirements for hospital and primary care EPR system providers to meet the specification of FLS assessments, treatment recommendations, communications to GPs and patients, patient monitoring, and data upload to the HQIP-commissioned FLS-Database would improve standards. Digital tools significantly improve the flow of patients through the FLS pathway, reduce the workload on healthcare staff, improve effectiveness, and patient safety.

Digital and IT-enabled systems developed during the pandemic have shown promise in supporting FLS across multiple sites through shared virtual multi-disciplinary teams (MDTs). The use of 'hub-and-spoke' models allows for economies of scale, making the most efficient use of the limited number of clinicians with osteoporosis expertise by allowing them to provide support across multiple FLS locations and facilitate sharing of best practice.

Depending on local need, the establishment of virtual MDTs would allow FLS practitioners to seek timely advice from specialists, thereby enhancing the quality of care provided to patients. This model is particularly useful in regions where specialist resources are scarce, as it maximises their availability and

supports more uniform service delivery. Furthermore, the use of digital platforms for patient management and follow-up could help ensure that patients complete their care pathway and receive the necessary interventions without gaps or delays.

3. Leveraging artificial intelligence in diagnostics

Artificial intelligence (AI) presents a valuable opportunity for the early identification of osteoporosis. AI methods are already beginning to be used in the NHS to evaluate CT scans, allowing for the rapid identification of patients with previously undiagnosed spinal fractures. Expanding the use of AI to identify high-risk patients can enable earlier intervention, thereby reducing the risk of severe fractures such as hip fractures. This would ultimately lead to better patient outcomes and reduced hospital admissions, supporting a proactive approach to osteoporosis management.

The use of AI, combined with automated alerts and digital integration of fracture risk assessment tools, could transform osteoporosis care by identifying at-risk patients earlier in the disease pathway. These advancements could also help healthcare professionals make evidence-based decisions and ensure that patients receive timely and effective care.

Q4: What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

Challenges

1. Unclear pathway towards universal Fracture Liaison Services coverage

Fracture Liaison Services (FLS) are the world standard for secondary fracture prevention, present in 55 countries, and capable of reducing re-fracture rates by 40%. Despite the government's commitment to provide universal FLS coverage by 2030, there is an unclear pathway towards achieving this goal. Current coverage is inconsistent with only 51% of NHS Trusts providing FLS, and many Integrated Care Boards lack a clear plan for implementing FLS. Further, the quality of current FLSs coverage is inconsistent with marked variation in patient identification, assessment, type of treatment offered and monitoring. FLS is crucial for identifying and supporting patients after a fracture, especially with supporting treatment adherence, but gaps in coverage mean many individuals are not receiving the timely support they need to prevent further fractures. Modest pump-priming is all that is needed to get these services up and running universally, because they break even within 18-24 months and can then be run sustainably from a portion of the savings.

2. Lack of awareness

The lack of understanding among healthcare professionals and the public about osteoporosis as a significant health concern leads to missed opportunities for early diagnosis.

3. Capacity constraints

Capacity constraints, particularly in diagnostic resources, exacerbate these challenges. DXA capacity is inadequate, with outdated equipment and a shortage of access points. In January 2024, there were only 15 Community Diagnostic Centres (11% of total centres at the time) providing DXA.²⁹

4. Fragmented case-finding efforts

The lack of a systemic case-finding solution for fractures and osteoporosis results in reliance on manual or individual secondary care and GP efforts, leaving many at-risk patients unidentified. Currently, 61% of patients who need a bone health assessment fall through the cracks due to individual clinician decision-making, which hinders early intervention and prevention.

²⁹ Smyth K. Written question UIN 17949: Osteoporosis: Screening. 2024 Mar 11. Available at: <https://questions-statements.parliament.uk/written-questions/detail/2024-03-11/17949/>

Enablers

1. Transformation Funding for FLS

Transformation Funding is critical for the successful delivery of universal FLS. The ROS has proposed a time limited period of funding to pump-prime FLSs until they reach the break-even point, after which the cost of running an FLS can be subsumed into Integrated Care Systems' budgets. This initial funding is necessary to overcome barriers and ensure FLSs are sustainable in the long term, ultimately leading to substantial cost savings for the NHS and social care by reducing future fracture rates. The experience in Wales has demonstrated that a Ministerial mandate alone is insufficient, with modest pump-priming necessary to achieve significant progress.

2. Joint venture for FLS rollout

The ROS has proposed a Joint Venture with NHS England to support the rollout of FLS by pooling expertise, backed by a Shadow National Implementation Group from ten expert societies that has already been convened. This approach aims to kickstart FLS by sharing best practice and learning to mitigate local capacity constraints and ensure that services meet the standards set by the HQIP-commissioned FLS Database. The proposal includes programme management for the rollout, co-production of local FLS plans, and hands-on support for Integrated Care Boards to achieve high-quality, sustainable FLS coverage.

3. Leadership and long-term condition recognition

Strong leadership is essential to address the challenges in osteoporosis care at every level of the NHS. The creation of a National Clinical Director or National Specialty Adviser for Fracture Prevention would provide the necessary leadership to drive improvements nationally and regionally. Recognising osteoporosis as a long-term condition would allow enhanced and equitable care and management of osteoporosis.

4. Collaborative case-finding efforts

Collaborative case-finding efforts involving community pharmacists and administrative staff could help systematically identify at-risk patients. Systematic identification of these patients would lead to significant gains in early diagnosis, reducing the risk of fractures and improving outcomes for patients. Case-finding could be complimented by a screening programme for high fracture risk.

Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

Quick to do (next year or so)

1. **Time limited pump-prime funding for universal Fracture Liaison Services pursuant to the Secretary of State's commitment on universal FLS coverage by 2030 with a clear rollout plan** – A modest pump-priming fund to cover costs until the services break-even at 18-24 months will be enough to achieve the rollout committed by Wes Streeting MP during the election.
2. **Agree Joint venture proposal to achieve the FLS rollout** – The Royal Osteoporosis Society has proposed a joint venture to co-deliver the FLS rollout with NHS England, through a pooling of expertise.
3. **Establish a National Clinical Director or National Specialty Adviser for fracture prevention and osteoporosis** – Create a leadership role within NHS England to provide coordination and visibility for osteoporosis care.
4. **Require all ICBs to produce an impact report of osteoporosis in their local community** – including a strategy to close the osteoporosis care gap
5. **Expansion of DXA scanning capacity through community diagnostic centres** – Increase access to bone density tests by adding DXA scanners, particularly in under-served areas. Ensure women's health hubs include osteoporosis assessments in their core specifications for comprehensive care.
6. **Prioritise osteoporosis as a long-term condition** – Osteoporosis must be given parity with other long-term conditions, and defined as such within the NHS, to allow enhanced and equitable care and management

In the middle (2 to 5 years)

1. **Improve case-finding in primary care settings** – Enable GPs to conduct data searches to identify high-risk patients for osteoporosis and integrate fracture risk assessments into GP systems.
2. **Use of AI in diagnostics** – Fully exploit digital technology and AI to improve opportunistic identification of people with key risk factors (undiagnosed vertebral fractures; low BMD) and streamline fracture prevention pathways.

3. **Integration of fracture risk assessment tools into GP IT systems** – Embed fracture risk tools in GP systems to streamline assessments and ensure patients at risk are promptly identified.
4. **Improve data sharing between primary and secondary care** – Promote shared patient records and standardised coding to improve care coordination and ensure timely follow-up.
5. **Digital tools for FLS** – Mandate providers for digital solutions in primary and secondary care to align with mandatory clinical audits and other data collection and reporting standards.
6. **Establishing a training academy for DXA practitioners** – Develop a robust system for training DXA operators, independent of voluntary sector reliance.
7. **Expand osteoporosis assessments within NHS Health Check for 40-74-year-olds** – Include osteoporosis in the NHS Health Check to facilitate early diagnosis and raise awareness of osteoporosis among healthcare professionals and the wider public.
8. **Introduce incentives for GPs to proactively manage osteoporosis** – Expand and enhance Quality and Outcomes Framework (QOF) incentives to adequately support the identification and monitoring of osteoporosis patients

Long-term change (more than 5 years)

1. **FLS standards compliance across all ICBs by 2030** – Ensure that all FLSs meet the clinical standards overseen by the HQIP-overseen Falls and Fragility Fracture Audit, including 80% identification of fragility fracture patients, 50% of patients being prescribed bone medication, and ensure 80% of patients receive treatment adherence follow-ups to maximise fractures prevented and cost savings.