# Fracture Liaison Service

# (Business Case Resource)

***This resource***

*This resource has been created by the Royal Osteoporosis Society as part of the Fracture Liaison Service Implementation Toolkit (FLS-IT). The aim of the toolkit is to take some of the hard work out of establishing a new Fracture Liaison Service or improving an existing one.*

*This resource has been created by working with NHS professionals from across the UK and makes use of current policy and recognised best practices. This resource and the other tools in the toolkit have been designed to save the user the time and trouble of researching, drafting and editing a document or workbook from scratch. References have been included where relevant.*

*Your organisation will have it’s own business case template, so where available you should always develop your business cases using your organisations internal templates, but you could use some of the information in this resource to populate it.*

*We trust that you will find this tool/template useful. You are free to use, change, edit or adapt this resource according to your requirements. If you have any queries or would like to make suggestions on how to improve the tool/template please contact us at the Royal Osteoporosis Society. If you would like to see or to download other tools please go to*[**https://theros.org.uk/healthcare-professionals/fracture-liaison-services/implementation-toolkit/**](https://theros.org.uk/healthcare-professionals/fracture-liaison-services/implementation-toolkit/)

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***Instructions for use***

*The resource is fully editable. Formatting has been kept to a minimum to allow flexible use when editing or copying material to use in local documents. The resource may include guidance on use and/or sections where local information may need to be entered. These sections have been highlighted* ***[using bold text in square brackets].*** *Please delete or overwrite these sections as necessary and make any font or formatting changes.*

***[Please delete this box when you use the template]***

## Contact details

|  |  |
| --- | --- |
| Organisation |  |
| Name of contact |  |
| Address for correspondence |  |
| Telephone |  |
| Email of lead contact |  |
| Email mailing list for circulation |  |

## Executive summary

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

This paper proposes the commissioning of an FLS for the **[patient population attending - insert organisation - OR the population of - insert appropriate CCG/Health Board]**. Once cost of service provision has been considered, the estimated net financial benefits to the health and social care economies over the next 5 years are **[benefits-costs=insert figure here]**.

**Why commission an FLS?**

The FLS model has demonstrated that it is uniquely effective in preventing secondary fractures by delivering assessments to 95-97% of at risk patients within the local population as opposed to only 25% of patients being assessed with other service models[[1]](#endnote-1). The FLS model is associated with increased treatment initiation and adherence to treatment (65%–88% at 1 year)[[2]](#endnote-2). Organisations with an FLS were found to have a 40% reduction in the 3-year risk of secondary fragility fractures to major bones and a 30% reduction of re-fracture to any bonecompared with organisations without an FLS[[3]](#endnote-3). FLS is associated with reduced mortality and it is cost-effective[[4]](#endnote-4). In May 2011, a formal cost-effectiveness analysis of the Glasgow FLS was published, which showed that between 1998-2008 the Glasgow FLS saw hip fracture numbers in Glasgow reduced by 7.3% versus an almost 17% increase in England (1.8% per year)[[5]](#endnote-5). Effective secondary fracture prevention throughout the NHS would prevent over 46,000 avoidable fragility fractures (including nearly 20,000 hip fractures) over 5 years in the UK[[6]](#endnote-6). In Glasgow, it was concluded that £21,000 was saved per 1,000 patients that were managed though the service[[7]](#endnote-7).

**Why commission an FLS at** **[insert name of the organisation]?**

Modelling, using estimates of benefits provided by the Royal Osteoporosis Society (ROS), indicate that implementing an FLS for **[insert organisation name]** will prevent approximately **[insert number of fractures prevented over 5 years, contact the ROS if you need help getting this figure]** fractures over 5 years[[8]](#endnote-8). An FLS will deliver financial benefits through the prevention of future fractures leading to a reduction in non-elective admissions. The current average acute length of stay following a hip fracture at **[insert organisation name]** is **[insert current average acute LOS for hip fracture]**. It has been estimated that over 5 years an FLS in this area could prevent **[insert number of preventable hip fractures, contact the ROS if you need help getting this figure]**, which equates to **[number of hip fractures prevented x average LOS for hip fracture]** acute bed days.

## Rationale for change

Fragility fractures are broken bones that result from mechanical forces that would not ordinarily cause a fracture, known as low-level (or 'low energy') trauma[[9]](#endnote-9). The World Health Organisation has quantified this as a force equivalent to a fall from a standing height or less[[10]](#endnote-10). Reduced bone density is a major risk factor for fragility fracture. Other factors that may affect the risk of fragility fracture include the use of oral or systemic glucocorticoids, age, sex, previous fractures and family history of osteoporosis[[11]](#endnote-11).

At age 50, the lifetime risk of fracture is greater than 50% for women and 20% for men[[12]](#endnote-12) and many of these will be fragility fractures. After a fragility fracture, patients are five times more likely to experience a second fracture within the next 2 years[[13]](#endnote-13). Half of all hip fractures are secondary fractures i.e. a fracture following a previous fracture[[14]](#endnote-14),[[15]](#endnote-15),[[16]](#endnote-16). Approximately half the number of hip fractures can be prevented if the patient is identified and treated following an initial non-hip fracture[[17]](#endnote-17).

Fragility fractures are the clinical manifestation of osteoporosis[[18]](#endnote-18). Osteoporosis is a condition characterised by low bone mass and micro-architectural deterioration of bone tissue with a consequent increase in bone fragility and susceptibility to fracture[[19]](#endnote-19). In 2015, 3.5million people in the UK were estimated to have osteoporosis[[20]](#endnote-20). Osteoporosis is a multifactorial condition, but prevalence increases sharply with age. In women the prevalence of osteoporosis increases from approximately 2% at age 50 to more than 25% at age 80[[21]](#endnote-21). Over 70% of UK population growth between 2014 and 2039 will be in the over 60 age group, an increase from 14.9 to 21.9 million people[[22]](#endnote-22). In 2017, over half a million fragility fractures occurred in the UK with an associated healthcare cost of £4.5billion. This annual expenditure is predicted to increase by 30%, to £5.9billion, by 2030[[23]](#endnote-23).

Unplanned admissions and length of stay are important drivers of cost, with emergency admissions due to fragility fractures taking up more acute bed-days than myocardial infarction, heart failure and stroke combined[[24]](#endnote-24). Hip fractures make up one fifth of all fragility fractures, yet they account for 58% of total fracture related costs[[25]](#endnote-25). Each year, hip fractures cost the UK healthcare system approximately £1.1billion/year[[26]](#endnote-26). At any one time, patients recovering from hip fracture occupy 1 in 45 beds in England and Northern Ireland, and 1 in 33 beds in Wales[[27]](#endnote-27).

Fragility fractures are a major obstacle to healthy aging. As well as the significant burden on health and social care resources, the consequence of fractures on the individual can be devastating. The impact of hip fracture is often recognised as precipitating the patient’s final illness. Only a minority of people completely regaining their previous abilities and a quarter require long-term care[[28]](#endnote-28).

Frailty is common in older people experiencing hip fracture and is a powerful predictor of adverse outcomes, including increased mortality and length of stay[[29]](#endnote-29).

The Department of Health’s 2009 strategy paper ‘Falls and Fractures: Effective Interventions in Health and Social Care’[[30]](#endnote-30) recognised that the consequences of falls and resultant fragility fractures cut across all local agencies working with older people. Accordingly, they identified four key areas for intervention that commissioners should consider in the context of local services for falls and fracture prevention. The document recommended developing services to achieve these four objectives, which were listed in priority order in terms of impact and evidence-base. Objective 1 was to improve patient outcomes and improve efficiency of care after hip fractures through compliance with core standards. Objective 2 was to respond to a first fracture and prevent the second through fracture prevention services. Objective 3 was early intervention to restore independence, through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries. Objective 4 was about preventing frailty, promoting bone health and reducing accidents, through encouraging physical activity and healthy lifestyles, and reducing unnecessary environmental hazards.

Objective 1 has largely been achieved following introduction of orthogeriatrican roles to improve the management of hip fracture patients on the ward, the Best Practice Tariff for hip fracture and the National Hip Fracture Database. However, there is still some way to go in terms of objective 2 as one in five women who have had a fragility fracture, will break three or more bones before they are diagnosed with osteoporosis[[31]](#endnote-31).

The FLS model, as recommended in Public Health England’s Falls and Fragility Fracture Consensus statement (2017) as an evidence-based, cost effective, preventative intervention that can help to improve the health of the population and reduce health and care service demand[[32]](#endnote-32). In addition, NHS RightCare, whose pathways are designed to support local health economies to concentrate their improvement efforts where there is greatest opportunity to address variation and improve population health, recommend that commissioners focus on three priorities including: falls prevention; detecting and managing osteoporosis and providing optimal support after a fragility fracture. They identify fracture prevention services, incorporating 4 and 12 month follow-up of patients, as a high value intervention on the basis that effective case-finding and appropriate drug treatment reduces risk of further fractures by up to 50%[[33]](#endnote-33).

## Local strategy

**[Link the requirement for an FLS to any relevant strategy or plan in your local trust or in the wider health economy e.g. falls, frailty, long term conditions, delayed transfers of care. Look at your local arrangements i.e. Clinical Commissioning Group (CCG) Operational plans will reflect the contribution of the CCG to the overall STP, check your STP for the individual CCG you are writing for, is there a Better Care Fund, a Primary Care Network, an Integrated Care System? What about operational plans for Health Boards – how does FLS fit with that strategy? Look at all local strategies available and show how investing in an FLS will help to meet any specific targets in these plans.]**

**[add the reference for your local strategy by adding another ‘endnote’ at the appropriate place under the ‘references’ tab in the ribbon in Word]**

**[add in the impact on social care:** Over a 5-year period, having an FLS at **[insert name of organisation]** has financial benefits to both the health and social care economy of **[contact the ROS if you need help getting this figure]**, with the social care element comprising of **[insert total benefits to social care, contact the ROS if you need help getting this figure]** of this[[34]](#endnote-34).

**If relevant to your locality: NHS RightCare: Commissioning for Value:**

**[Look up the relevant CCG RightCare MSK data pack here:**

<https://www.england.nhs.uk/rightcare/intel/cfv/data-packs/>

**If appropriate. list the specific opportunities highlighted related to osteoporosis assessment and treatment to show how investing in an FLS will help address them as described below]**

The Commissioning for Value packs for **[insert name(s) of the CCGs]** demonstrate, that measured against their 10 comparative CCGs there is opportunity for improvement in the following areas[[35]](#endnote-35): **[for example……**

* **There is a higher rate of hip fractures in people age 65+**
* **There is a lower proportion of patients age 75+ with fragility fracture treated with bone sparing agent]**

Commissioning an FLS will help address the opportunities highlighted above.

## Local case for change

**[contact the ROS if you need help to calculate the estimated number of fractures in your population, if you can not do this yourself]**

**[Insert local information here, for example:**

* **Area to be covered by the service**
* **Population size including, if possible, details of the population to be covered by the service e.g. over 50s**
* **Population and demographic trends**
* **Incidence of fragility fractures**

**Outline key issues and reasons for change. This might include:**

* **No FLS in place**
* **High or above average number of falls in over 50s**
* **Increasing number of fractures occurring in over 50s**
* **Lack of coordinated follow up of patients who have experienced a fall and subsequent fracture**
* **High number of recurring fractures**
* **High proportion of patients unable to live independently following a fall or previous fracture]**
* **Current services and pathways and associated costs**

## Aims and Outcomes of the FLS

The **aims** of the FLS are:

* Improve the quality and experience for the individual and their family by ensuring secondary fracture prevention is delivered to agreed national and local standards.
* Improve equity of service, with equal access to effective secondary prevention for the whole population.
* Increase cost-effectiveness by reducing variation and delivering best practice through locally agreed standardised pathways for bone health interventions for secondary fracture prevention.
* In the long-term, reduce the incidence of fragility fractures.
* In the long-term, reduce costs to the local health economy through effective secondary fracture prevention.

The **objectives** of the FLSare to deliver care in line with the published [Royal Osteoporosis Society Clinical Standards for FLS](https://theros.org.uk/media/1eubz33w/ros-clinical-standards-for-fracture-liaison-services-august-2019.pdf); shown in the table below:

|  |  |
| --- | --- |
| **Standard/Aim** | **Criteria/Objectives** |
| **1** **Identify:** People aged 50 years and over with a fragility fracture are systematically identified | **1.1** The FLS identifies people aged 50 years or older with a new fragility fracture which also includes:  • Newly identified vertebral fracture.  • A new fracture occurring whilst a patient is taking an osteoporosis drug treatment. |
| **2 Investigate:** Investigations to assess risk of fragility fractures and falls and possible underlying secondary causes for osteoporosis are offered to people identified by the FLS. | **2. 1** People identified as being at increased risk of another fragility fracture are offered an assessment which will include:  • A fracture risk assessment including use of FRAX or QFracture and quality assured axial DXA including a vertebral fracture assessment (VFA) where indicated.  • An assessment of falls risk in people aged 65 or over.  • Relevant laboratory and imaging investigations to identify any underlying secondary causes of osteoporosis and help inform drug treatment decisions.  **2.2.** Assessment will be completed within 12 weeks of fracture diagnosis. |
| **3** **Inform:** Information and support are offered to people (and where relevant their carers) using the FLS. | **3.1.** People are offered information according to their needs about:  • Osteoporosis and risk factors for fracture.  • Lifestyle interventions aimed at reducing fracture risk including nutrition and exercise.  • Coping with pain and any disability associated with their fracture.  • Drug treatment options for osteoporosis - including information on benefits and side effects.  • Reducing falls risk.  • Next steps in their care plan including follow-up appointments.  **3.2.** Information is available in a range of formats and languages, appropriate to the population covered by the service.  **3.3.** People and their carers understand where to get further information about osteoporosis and support following their appointment.  **3.4.** Communications from the FLS are written in a style that can be understood by the person and their carers. Communications are copied to the person who has had a fracture as well as the healthcare professionals involved in their care, including their GP. People feel supported and empowered to make informed choices and reach shared decisions about their management plan. |
| **4 Intervene:** Interventions to reduce the risk of fragility fractures are offered to people as required. | **4.1.** People at high risk of fragility fracture are initiated on an appropriate osteoporosis drug treatment within 16 weeks of fracture diagnosis (i.e. within 4 weeks of the assessment being completed).  **4.2.** People at high risk of falling are referred to falls prevention services and offered interventions within 16 weeks of their fracture to maximise balance and mobility.  **4.3.** People who are recommended interventions to reduce risk of fracture will be reviewed by the FLS within 16 weeks of fracture and at 52 weeks to ensure:  • Treatment has been started and taken appropriately.  • Referral to falls reduction programmes has been actioned.  **[Local methods for follow up to be agreed; it is usually a telephone call]** |
| **5 Integrate:** The FLS will integrate with the wider healthcare system to facilitate an inclusive patient pathway; ensuring effective case-finding, onward referrals and longterm management of osteoporosis | **5.1.** Clear management plans are prepared to facilitate transfer of patient care into primary care, enabling the long-term management of osteoporosis.  **5.2.** The FLS staff maintain relationships with relevant in-hospital services.  **5.3.** The FLS staff have a good understanding of the available out-of-hospital services and how people using the FLS can access these.  **5.4.** Referral pathways between the FLS and relevant services are agreed.  **5.5**. People who are recommended interventions to reduce risk of fracture will be reviewed annually to monitor adherence, tolerability and unwanted effects of their treatment plan. After the initial 52 review, the FLS will handed over to Primary Care, for long term osteoporosis management.  **5.6.** Staff participate in a local multidisciplinary fracture prevention interest group which meets regularly to co-ordinate, plan and develop the FLS. |
| **6 Quality:** The FLS demonstrates clinical accountability, ongoing quality improvement, effective governance and funded access to continuing professional development for all practitioners. | **6.1.** A designated lead clinician is accountable for all components of the service.  **6.2.** The FLS is developed in line with a local falls and fracture prevention strategy.  **6.3.** Core data from people identified by the FLS is recorded on an operational database.  **6.4.** A quality assurance framework is in place that includes:  • A programme of continuous improvement including regular audit.  • Participation in national audits such as the [Fracture Liaison Service Database](https://www.fffap.org.uk/fls/flsweb.nsf/) **[in England and Wales]** or the Hip Fracture Audit **[in Scotland]**..  • Peer review.  • Patient and carer experience measures.  **6.5.** All members of the FLS team have assessment of professional competencies and demonstrate continuing professional development.  **6.6.** Staff are active participants in a regional clinical or professional network. |

**Outcomes:** A set of 11 KPIs were developed by the [Fracture Liaison Service Database (FLS-DB)](https://www.fffap.org.uk/fls/flsweb.nsf/) multidisciplinary advisory group, which includes patient representation. All the KPIs are based on NICE technology assessments and guidance on osteoporosis and the Royal Osteoporosis Society (ROS) clinical standards for FLSs. The FLS should aim to deliver these KPIs as part of their service.

**Five core KPIs**

**KPI 1 Data completeness:** The number of non-mandatory fields with >20% non-mandatory missing data

**KPI 2 Identification of all fragility fractures:** The percentage of fragility fracture patient records that were submitted to the FLS-DB compared with the local expected case load

**KPI 4 Time to FLS assessment:** The percentage of patients who were assessed by the FLS within 90 days of their fracture

**KPI 9 Monitoring contact 12–16 weeks post fracture:** The percentage of patients who were followed up by 12–16 weeks post fracture

**KPI 10 Commenced bone therapy by 16 weeks post fracture:** The percentage of patients who had commenced (or were continuing) anti-osteoporosis medication by 16 weeks post fracture.

**Six additional KPIs**

**KPI 3 Identification – spinal fractures:** The percentage of patients with a spine fracture as the primary fracture site whose data were submitted to the FLS-DB

**KPI 5 Time to DXA:** The percentage of patients who received a DXA scan within 90 days of their fracture

**KPI 6 Falls assessment:** The percentage of patients who had been referred or recommended for, or had received, a falls assessment

**KPI 7 Bone therapy recommended as inappropriate:** The percentage of patients for whom a treatment recommendation was recorded as ‘clinical decision not to treat or inappropriate’

**KPI 8 Strength and balance training:** The percentage of patients who had attended a strength and balance class within 16 weeks of their fracture

**KPI 11 Adherent to a prescribed anti-osteoporosis drug 12 months after their fracture:** The percentage of patients who had confirmed adherence to a prescribed anti-osteoporosis drug at 12 months post fracture.

**[Please edit for any local aims, objectives and Outcomes]**

## Outline of the proposed service

The establishment of an FLS, for patients aged over 50, who sustain a low impact (fragility) fracture, acquired following a fall, slip or trip from a standing height; with the primary aim of preventing subsequent fracture.

There will be a designated lead clinician is accountable for all components of the service. The service will promote coordination between both in-hospital (e.g. acute) and out-of-hospital (e.g. community, primary care) health settings; to ensure that care is seamless and consistent and will be in line with the [Royal Osteoporosis Society Clinical Standards for FLS](https://theros.org.uk/media/1eubz33w/ros-clinical-standards-for-fracture-liaison-services-august-2019.pdf), as shown in the table in Section 6.

## The final clinical pathway will be mapped at a stakeholder event following the successful approval of this business case, however this is an outline of the proposed service in line with current national standards [if you already have a proposed clinical pathway, please insert here and edit previous description as appropriate]:

#### 

**[If you have already developed a service specification you might attach this as an appendix to your business case]**

## Financial assessment

**[Include details of the costs of the service you are planning to set up. The way that costs are calculated and displayed will vary locally. Advice from your business manager, finance team and/or your commissioner (where the commissioning organisation is the budget holder) should be sought at this point. An example of information that may be included is shown in Appendix 1, but please use provide information required by your organisation.**

**This section brings together the financial information in a simple calculation known as a cost/benefit analysis, which is:**

**Estimated value of benefits**

**minus**

**Additional investment**

**=**

**Net benefits**

**Each part of the calculation should be clearly described and then brought together in a single table. This is a vital element of your business case as the net benefits may then be compared with other projects competing for funds. An example of this is shown in Appendix 1]**

## Implementation

**[Include information on the steps you will take to launch the service including details of recruitment, facilities, communications, FLSDB data entry and so on. Include dates where possible. The ROS can help you with this].**

## Risk and issues management

**[Examples of possible risks are given below. These should be edited to fit local circumstances and mitigation actions added.]**

**Risks to successful mobilisation of the FLS**

|  |  |
| --- | --- |
| **Risk** | **Mitigation** |
| Suitably qualified staff are not available through recruitment | Consider secondment opportunities  Research best options for advertisement  Additional training for example the [Fracture Prevention and Practitioner Training](https://theros.org.uk/healthcare-professionals/courses-and-cpd/fracture-prevention-practitioner-training/). |
| Current facilities not suitable | Review alternative service locations |
| DXA capacity may not be adequate to cope with additional demand |  |
| **[Other risk here]** | **[Mitigation action here]** |

**Risks following commencement of the service**

|  |  |
| --- | --- |
| **Risk** | **Mitigation** |
| Patient numbers do not reach the expected levels | Additional communications activities e.g.   * Secure ‘slot’ at practice learning event * Arrange meeting with senior fracture clinical nurse and consultant |
| Patient numbers exceed the expected levels | Review model estimates  Consider change to referral criteria  Consider making request for additional staff |
| Reduction in expected fracture numbers does not materialise | Check data collection is complete  Review statistical measures |
| **[Other risk here]** | **[Mitigation action here]** |

## Recommendations

## [The recommendations here will depend entirely on the contents of the business case and what stage you are at. You need to be clear what you are asking from your Senior Management Team or Commissioners].

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

1. **References:**

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    **Appendix 1: Example of financial section for business case.**

    **Benefits:**

    It has been estimated that having an FLS at **[insert name of organisation]** will prevent a total of **[insert total number of fractures prevented, contact the ROS if you need help getting this figure]** fractures over 5 years, which is shown in the table below:

    **[insert table, with the number of fractures prevented over 5 years, contact the ROS if you need help getting these figures]**

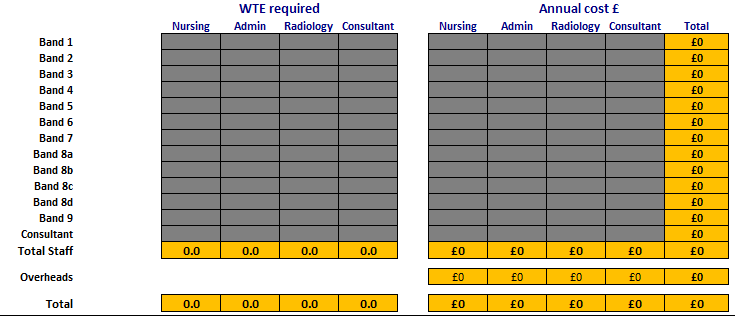
    |  |  |  |  |  |  |
    | --- | --- | --- | --- | --- | --- |
    |  | **Year** | **Hip fracture (inpatient)** | **Other fracture site (inpatient)** | **Other fracture site (outpatient)** | **Clinical vertebral** |
    |  | **1** |  |  |  |  |
    |  | **2** |  |  |  |  |
    |  | **3** |  |  |  |  |
    |  | **4** |  |  |  |  |
    |  | **5** |  |  |  |  |
    |  | **All years** |  |  |  |  |

    Based on the number of fractures prevented, the ROS FLS Benefits Calculator **[if you are able to do this yourself please delete ROS Calculator reference here]** estimates that the expected gross benefit to the local health and social care system by having an FLS based at **[insert name of organisation]** is shown below:

    |  |  |  |  |  |  |  |
    | --- | --- | --- | --- | --- | --- | --- |
    | **Year** | **Hip fracture (inpatient)** | **Other fracture site (inpatient)** | **Other fracture site (outpatient)** | **Clinical vertebral** |  | **Total** |
    | **1** |  |  |  |  |  |  |
    | **2** |  |  |  |  |  |  |
    | **3** |  |  |  |  |  |  |
    | **4** |  |  |  |  |  |  |
    | **5** |  |  |  |  |  |  |
    |  |  |  |  |  |  |  |
    | **All years** |  |  |  |  |  |  |

    **Costs:**

    To fully staff the FLS to deliver the service to national standards, staffing costsin terms of wholetime equivalents, including on-costs and overheads **[show overhead percentage here]**, are shown in the table below: **[the ROS can help you understand what resources may be required, if necessary]**

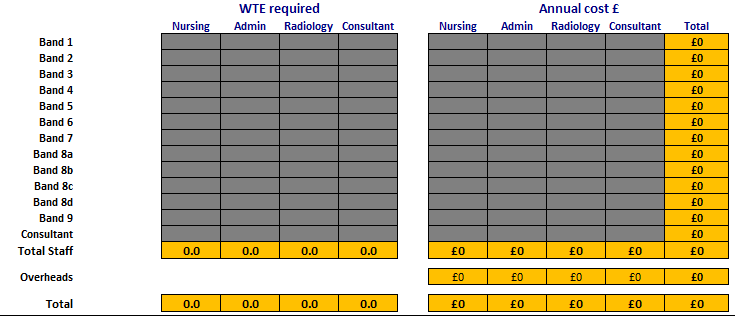
    

    **Additional Investment:**

    The additional investment required to implement the service will be:

    **[Additional investment comprises the costs of the service that you plan to establish, less any elements of the service that are already in place. For example, if you already have a specialist nurse who will now work in the new service and this post will be incorporated into the new service then this cost is effectively zero. If you need to request funding for the full staff complement you do not need the table above, as it will be the same as the table below. Please clearly state what you are asking for, including any training highlighted, be aware of the impact on existing services when establishing any changes in job roles. Some examples are shown below, please note not all may be appropriate for your case]**

    **Additional Resources required:**

    **Training costs associated with set up and running of FLS:**

    **[Establish the training requirements here, things to consider are:**

    <https://theros.org.uk/healthcare-professionals/courses-and-cpd/>

    * **Fracture Prevention Practitioner Training**
    * **National Training Scheme for Bone Densitometry**
    * **Bone Densitometry Foundation Course]**

    |  |  |  |
    | --- | --- | --- |
    |  | **Training** | **Costs** |
    | **Year 1** |  | £0 |
    | **Year 2** |  | £0 |
    | **Year 3** |  | £0 |
    | **Year 4** |  | £0 |
    | **Year 5** |  | £0 |

    An estimation of the additional number patients requiring treatment from primary care and DXA scans for this patient population, compared with standard care, are shown in the tables below: **[the ROS can help you with some of the data for the following tables – you may need to determine your costs locally]**

    **Additional Primary Care Prescribing Costs:**

    |  |  |  |  |
    | --- | --- | --- | --- |
    |  | **Expected additional cases on treatment** | **Cumulative cases on treatment** | **Cost of cumulative cases** |
    | **Year 1** | 0 | 0 | £0 |
    | **Year 2** | 0 | 0 | £0 |
    | **Year 3** | 0 | 0 | £0 |
    | **Year 4** | 0 | 0 | £0 |
    | **Year 5** | 0 | 0 | £0 |

    This is the estimated additional increase in primary care prescriptions as a result of having the FLS in place, compared to standard care.

    **Cost of Additional DXA Scans and Reports [if paid for at tariff]:**

    **[The cost of the providing DXA scans will** **need to reflect local pathways/contracting i.e. whether you are asking for additional resource – which would need to be added to the ‘resource’ table above - to complete the DXAs and report them or whether this will be paid for at tariff]**.

    |  |  |  |
    | --- | --- | --- |
    |  | **Expected additional scans** | **Cost of additional scans** |
    | **Year 1** | 0 | £0 |
    | **Year 2** | 0 | £0 |
    | **Year 3** | 0 | £0 |
    | **Year 4** | 0 | £0 |
    | **Year 5** | 0 | £0 |

    This is the estimated additional number of DXAs required as a result of having the FLS in place, compared to standard care.

    **Summary of all costs:**

    |  |  |  |  |  |  |
    | --- | --- | --- | --- | --- | --- |
    |  | **FLS cost** | **Additional Primary Care Prescribing Cost** | **Additional DXA scans at tariff** | **Training Costs** | **All costs** |
    | **Year 1** | £0 | £0 | £0 | £0 | £0 |
    | **Year 2** | £0 | £0 | £0 | £0 | £0 |
    | **Year 3** | £0 | £0 | £0 | £0 | £0 |
    | **Year 4** | £0 | £0 | £0 | £0 | £0 |
    | **Year 5** | £0 | £0 | £0 | £0 | £0 |
    | **All years** | **£0** | **£0** | **£0** | **£0** | **£0** |

    **[may not need to include all columns here e.g. training or DXA if not paid at tariff].**

    **Net Benefits:**

    The net benefits of having an FLS in place at **[insert name of organisation]** can be seen in the tables below:

    **[the ROS can help you populate these tables]**

    |  |  |  |  |
    | --- | --- | --- | --- |
    |  | **Costs** | **Benefits  (NHS & social care)** | **Difference** |
    | **Year 1** |  |  |  |
    | **Year 2** |  |  |  |
    | **Year 3** |  |  |  |
    | **Year 4** |  |  |  |
    | **Year 5** |  |  |  |
    | **All years** |  |  |  |
    |  |  |  |  |
    |  |  |  |  |
    |  | **Costs** | **Benefits  (NHS only)** | **Difference** |
    | **Year 1** |  |  |  |
    | **Year 2** |  |  |  |
    | **Year 3** |  |  |  |
    | **Year 4** |  |  |  |
    | **Year 5** |  |  |  |
    | **All years** |  |  |  |

    [↑](#endnote-ref-35)