



Guide to the formation of national Fragility Fracture Networks

Fragility Fracture Network

December 2018



Contents

The rationale for establishing national FFNs	3
The Global Call to Action.....	4
The process of initiating a national FFN.....	5
Step 1: Engagement with activists from the core national health professional associations	5
Step 2: Inaugural meeting to establish a national FFN	6
Broadening engagement of national FFNs.....	7
Immediate goals.....	7
Core national health professional societies.....	7
Other national health professional societies	7
Non-governmental organisations	7
Private sector organisations	8
Subsequent goals	8
Health system leaders.....	8
Insurers (public and private)	9
National policymakers	9
Projects that can be coordinated by national FFNs	10
Consensus guidelines	10
Clinical standards	10
Benchmarking with national databases.....	10
The role of national FFNs in education and workforce development	11
The role of national FFNs in driving policy change	12
Policy goals.....	12
Relationship between national FFNs and the global FFN	13
The Regionalisation Committee (RegCom).....	13
National FFN websites	13
Regional FFN meetings.....	14
Useful resources	14
Multidisciplinary co-management in the acute phase after fracture.....	14
Multidisciplinary rehabilitation.....	14
Secondary fracture prevention.....	14
National FFNs and other national alliances	15
Programme for a multidisciplinary national meeting.....	16
RegCom terms of reference.....	19
References	22



The rationale for establishing national FFNs

The global population is currently ageing at an unprecedented rate [1]. A direct consequence of this “longevity miracle” will be an explosion in the incidence of chronic diseases which afflict older people. In response to this challenge, policymakers throughout the world need to develop and implement strategies that will ensure older people can continue to live healthy, happy and fulfilling lives. These strategies must minimise the burden imposed by chronic disease on individuals, their families, health systems and national finances.

Fragility fractures are a major threat to older people’s quality of life, causing pain and loss of mobility and the capacity to remain independent and living in their own home.

Key observations include [2]:

- In 2010, the number of individuals aged 50 years and over at high risk of osteoporotic fracture worldwide was estimated at 158 million and is set to double by 2040
- In the same year, the global incidence of hip fracture was estimated to have reached 2.7 million cases per year
- The costs associated with fragility fractures are staggering:
 - In 2010, the 3.5 million fragility fractures which occurred in the European Union cost Euro 37 billion
 - By 2025, the annual incidence of fragility fractures in the United States is projected to exceed 3 million cases, at a cost of US\$25 billion
 - Recent projections from the Asian Federation of Osteoporosis Societies (AFOS) suggest that more than 1.1 million hip fractures occurred in nine Asian countries/regions in 2018 at a cost of US\$9.5 billion, figures which are set to increase to 2.6 million hip fractures at a cost of US\$15 billion by 2050 [3]

The two key factors that lead to fragility fractures are (i) osteoporosis and (ii) the tendency to fall; both are treatable, enabling – in principle – a preventive strategy. For those fractures that do occur, more cost-effective treatment can be delivered by a multidisciplinary approach that combines the skills of the surgeon with those of physicians, nurses and rehabilitationists. These lessons have been learned and reinforced in many countries. Furthermore, we have learned that multidisciplinary national alliances, speaking with a unified voice, are effective in persuading politicians and managers to make the healthcare policy changes necessary to ensure that service improvement actually happens on a broad scale in any given country.



The Global Call to Action

In 2018, the Fragility Fracture Network (FFN) - in collaboration with 80 leading professional organisations for geriatric medicine, orthopaedics, osteoporosis, rehabilitation and nursing – launched a Global Call to Action (CtA) [4]. This defined four “pillars” that would bring about substantial improvements in the care of people who sustain fragility fractures:

1. Acute multidisciplinary care for people who suffer hip, clinical vertebral and other major fragility fractures
2. Rehabilitation and ongoing post-acute care of people whose ability to function is impaired by hip and other major fragility fractures
3. Rapid secondary prevention after first occurrence of all fragility fractures, including those in younger people as well as those in older persons, to prevent future fractures
4. Formation of national alliances between relevant professional associations to persuade politicians and promote best practice among colleagues

The actions needing to be performed by the multidisciplinary alliances were specified as:

- To speak with a unified voice to policy makers
- To produce consensus guidelines setting clear standards for adequate care using the best available research evidence, and propose metrics to evaluate performance
- To expand education programmes that can build the multidisciplinary workforce capable of delivering evidence-based best practice on a wide scale

The purpose of this booklet and associated web-based resources is to help to turn the CtA into Actual Action by supporting colleagues in countries that currently do not have a national alliance. A national FFN (nFFN) will catalyse the creation of the multidisciplinary national alliance that is referred to above. At the same time, the links between national FFNs and the global FFN will generate the efficient exchange of experience and inspiration that will help in driving things forward.

In countries which have already established a national alliance relating to aspects of acute care of fragility fractures, secondary fracture prevention or post-fracture rehabilitation, FFN global welcomes such alliances to consider the approach described in the CtA and in this booklet. FFN global is committed to supporting national alliances that share our strategic priorities, whether constituted as a nFFN or not. Please note that the FFN (both globally and nationally) is deliberately constituted as a **network**. It does not aim to supplant or compete with existing professional associations; its purpose is to facilitate collaboration between existing associations.



The process of initiating a national FFN

The initiation of a national FFN (nFFN) does not require a large number of people. But it does require the right mix of people: representatives of all the disciplines which do, or should, play a role in the management of patients who present with a fragility fracture, including acute care, rehabilitation and secondary prevention.

Step 1: Engagement with activists from the core national health professional associations

It is for the activists initiating the nFFN to determine, in the context of their country, which societies constitute the core of a national alliance. However, we recommend that the initiating group should normally have members of the national associations for:

- *orthopaedics*; this is absolutely essential, because most fragility fractures present to the orthopaedic community. Without their involvement, little can change.
- *geriatrics*; if there are few or no geriatricians available, include other physicians (eg internal medicine), but with the understanding that *frailty* is the key issue with elderly fracture patients
- *rehabilitation*; if a separate discipline of physiatry or similar exists in your country
- *osteoporosis*; may be endocrinologists, geriatricians, rheumatologists etc
- *nursing*
- *physiotherapy*

Initially, the activists assembled to initiate the nFFN may or may not be senior in their respective professional associations and they may or may not be authorised to speak on those organisations' behalf. Of course, the objective is to secure the buy-in of whole associations but, at the very beginning, the key thing is that the individuals assembled should be committed activists who 'get it' about multidisciplinary. If they make it their business to respectfully *inform* their associations of developments in the nFFN and seek advice on appropriate issues, then trust and engagement will gradually develop.

The initiators of a nFFN can seek engagement of the national health professional societies by formally inviting them to endorse the Global Call to Action (CtA, see box). The FFN global website has a section dedicated to that process. Making that request can be used as a 'calling card' to open a dialogue with that association and enable the identification of those of its members who are most likely to be interested in the project.



Prior to publication, organisations for geriatric medicine, orthopaedics, osteoporosis, rehabilitation and rheumatology were invited to endorse the CtA. These included organisations operating at the global level, regional level (Asia Pacific, Europe, Latin America, and Middle East and Africa) and at the national level for five highly populated countries (Brazil, China, India, Japan and the United States). Since publication, many national societies from other countries have offered their endorsement of the CtA and have pledged to work collaboratively with their national “sister” organisations to implement its recommendations.

Given that the fourth pillar – the importance of multidisciplinary national alliances – is explicit in the CtA, if endorsement is offered by one of the core societies, de facto, a commitment has been made to work collaboratively with other national health professional associations to establish a national alliance.

Step 2: Inaugural meeting to establish a national FFN

Having assembled an appropriate, discipline-balanced, initiating group that is resolved to create a nFFN, the next step is to convene a meeting of that group to formally explore the idea of a nFFN, or to actually launch the organisation. Priority subjects for discussion will likely include:

- Agreement on a governance structure with appropriate multidisciplinary representation, to be laid out in Articles of Association
- Agreement on a process to elect or appoint individuals to the posts of President/Chair, General Secretary, Treasurer, etc and the other Board members. A combination needs to be found, between democratic openness and central coordination, that delivers balance between disciplines, geographical regions and gender.
- The composition of the ‘Foundation Board’ that will run the Network until such time as elections can be held.
- Agreement on a process to define the vision, mission and strategic objectives
- An assessment of initial funding needs and a strategy to secure those start-up costs
- Agreement on a strategy to broaden engagement (see next section)
- Identification of projects to deliver the strategic objectives (see section on “Projects to be coordinated by national FFNs”)
- Assessment of the national educational and workforce development needs and consideration of what the nFFN can do to help meet them



- Agreement on a process to develop a communication strategy to raise awareness of the formation of a nFFN and subsequent projects (to include website development and social media presence)
- Agreement on a process to develop an advocacy strategy to drive policy change

Broadening engagement of national FFNs

Based on prior experience from countries that have established nFFNs or other similar national alliances, there are two distinct phases to broadening engagement, following the establishment of the nFFN.

Immediate goals

Core national health professional societies

In the initiation phase, we stressed the importance of including activists from all the relevant national professional societies. This lays the foundation for broader engagement with the membership of those societies; achieving that is a high priority for the nFFN communication strategy. Both the leadership and the general membership of each society need to be engaged if the nFFN is to implement its strategic objectives. Look for creative ways to communicate the existence, *raison d'être* and strategic focus of the nFFN, and how individual society members can contribute to improving the care of individuals who sustain fragility fractures.

In practice, this will probably involve allocation of time at national society annual meetings to joint symposia with the nFFN, showcasing the nFFN through society communication channels and editorial/opinion piece publications describing the nFFN in society journals.

Other national health professional societies

Well-established national alliances have sought also to engage with a wider range of national societies, covering all professional groups involved in the management of people who sustain fragility fractures. This might include societies for anaesthetics, endocrinology, exercise and sports science, falls prevention, family physicians/general practitioners, frailty, physiotherapy, musculoskeletal medicine, nutrition, obstetrics and gynaecology, orthopaedic nursing, pharmacy, physiatry, public health, radiology and sarcopenia. As described above for the core national societies which participate in the initiation of the nFFN, once the society leadership is engaged, an effort must be made to engage broadly with the membership.

Non-governmental organisations

In addition to engagement with a range of national healthcare professional societies beyond the core specialties, a nFFN has the potential to be strengthened by engaging with relevant non-governmental organisations (NGOs). While the national osteoporosis society would naturally be considered a core society, this could include NGOs which focus on general advocacy for older people (e.g. Age Concern,



Age UK, HelpAge International national affiliates), carers organisations and groups focused on women's health.

Private sector organisations

The Global Call to Action on Fragility Fractures called for the following specific actions to be taken by industry:

- To respond to care and service needs by developing and evaluating new products and technologies intended to improve patient outcomes through clear patient value
- To work collaboratively with professional societies, government organisations, universities, insurers and health care systems in the development and evaluation of these products and technologies
- To advocate globally for implementation of systematic approaches to fragility fracture care and fracture prevention like Orthogeriatric Services (OGS) and Fracture Liaison Services (FLS)

With regard to the third action point, it is for the leadership of a nFFN to decide whether it includes within its ranks industry partners or not. The global FFN has considered industry partners as genuine partners, within the limits of compliance rules, from its inception.

Subsequent goals

At the point that the nFFN has clearly defined its strategic objectives and broadened engagement with individual clinical activists, national health professional societies, NGOs and, possibly, industry partners, the subsequent phase of wider engagement can begin. This may take several years.

Health system leaders

Seeking engagement with health system leaders, in both the public and private sector, can create a platform for dialogue to explore how the nFFN's strategic objectives can fit within the broader context of priorities for health systems.

Highlighting synergies with existing quality improvement initiatives in other therapeutic areas is likely to promote a positive response from such leaders. An illustration of such an approach that has been employed in several countries is the potential for constructive interaction between fragility fracture services and services for people who are living with dementia. The most common reason that individuals who are living with dementia present to urgent care services is a fall or fracture. Accordingly, an opportunity exists to establish robust pathways to ensure that individuals who fall or fracture benefit from access to memory clinics [5]. Correspondingly, patients who attend memory clinics will commonly be at elevated risk of sustaining falls and fractures, and so could benefit from referral to prevention services to manage osteoporosis and falls risk. Recognising the "bigger picture" challenges health system leaders face across the broad spectrum of medical care that their systems provide is likely to engender a positive reception to the nFFN strategy.



Insurers (public and private)

The Global Call to Action on Fragility Fractures called for the following specific actions to be taken by insurers:

- To reimburse the most effective services to improve the management and fracture prevention in people who sustain a fragility fracture
- To incentivise where appropriate the delivery of best care
- To provide additional resources for research on best practices for care of people who sustain fragility fractures

As insurers in both the public and private sector often play a critical role in determining what aspects of care are reimbursed or not, developing a robust plan for engagement with these organisations is of great importance.

National policymakers

The ultimate goal of a nFFN would be to seek meaningful engagement with national policymakers to stimulate governments to deliver the specific actions highlighted in the Global Call to Action:

- To respond to the threat posed to their societies from fragility fractures
- To recognise the critical role that they play in establishing health systems capable of addressing this challenge
- To prioritise acute and long-term fragility fracture care and prevention in National Health Strategies
- To increase funding available to develop, implement and test care models (i.e. OGS and FLS) designed to improve outcomes for people with fragility fractures

While achieving engagement with policymakers may seem aspirational, at least two national alliances have achieved precisely this. The National Bone Health Alliance (NBHA) in the United States had government liaisons from five agencies: Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), National Aeronautics and Space Administration (NASA), National Institutes of Health (NIH) and U.S. Food and Drug Administration. The Live Stronger for Longer alliance in New Zealand is comprised of the Accident Compensation Corporation (ACC, a “Crown Entity”), Ministry of Health (MOH), Health Quality and Safety Commission (HQSC), in addition to District Health Boards, Primary Health Organisations, health professionals, home carers and community groups, all focused on delivering optimal services to older people. Further, in October 2018, the New Zealand government agencies were the first such organisations in the world to endorse the Global Call to Action, setting a precedent that other governments could be invited to follow.



Projects that can be coordinated by national FFNs

A range of projects and activities could be led and/or coordinated by nFFNs, including the following. These relate to the strategic objectives of the global FFN.

Consensus guidelines

Each country needs a set of guidelines relating to the acute management, rehabilitation and secondary prevention of fragility fractures. Many examples of consensus guidelines exist relating to the acute multidisciplinary management and secondary prevention of fragility fractures, including the following:

- Australian and New Zealand (ANZ) Guideline for Hip Fracture Care [6]
- Libro Azul de la Fractura Osteoporótica en España [7]
- The care of patients with fragility fracture (UK) [8]

Clinical standards

Clinical or quality standards identify specific standards of care pertaining to the various components of management of people with fragility fractures, which can readily enable benchmarking of standards of service provision. Clinical standards are derived from the best practice recommended in consensus guidelines. Examples for both acute multidisciplinary management and secondary prevention of fragility fractures include the following:

- Acute multidisciplinary management delivered by Orthogeriatric Services:
 - Hip Fracture Care Clinical Care Standard (ANZ) [9]
 - NICE Quality Standard 16: Quality standard for hip fracture care (UK) [10]
- Secondary fracture prevention delivered by Fracture Liaison Services:
 - International Osteoporosis Foundation (IOF) Capture the Fracture® Program [11]
 - Clinical Standards for Fracture Liaison Services (UK) [12]

Benchmarking with national databases

National databases have been developed in several countries to enable benchmarking of the delivery of care against clinical standards. In 2017, the development and impact of national hip fracture registries was described by Johansen et al [13]. The UK National Hip Fracture Database (NHFD) is now the largest continuous audit of acute hip fracture care and secondary fracture prevention in the world, with more than 600,000 cases documented since launch of the NHFD in 2007 [14]. Development of the ANZ Hip Fracture Registry (ANZ HFR) was significantly informed by experience from the UK NHFD [15]. In 2018, the first ANZ HFR annual report to present data on a named hospital basis was published [16].



Emerging examples of analogous FLS Databases include the national FLS Database developed in the UK [17] and the American Orthopaedic Association's Own the Bone® database in the United States [18].

The role of national FFNs in education and workforce development

Multidisciplinary management of fragility fractures is complicated and the global FFN aims to lift the level of treatment globally by education and dissemination of evidence-based treatment principles. In the acute management of older patients with fragility fractures, the orthogeriatric model, although the most effective model and well-established in some countries, remains unknown in many others, especially the developing economies: in some countries, the speciality of geriatric medicine does not exist. We have, therefore, to explain what is beneficial about the orthogeriatric approach and help colleagues to provide it.

Education on a global level is important but nFFNs can be more effective because they know the specific needs and possibilities existing in their own countries. By bringing together activists and opinion leaders from the relevant mainstream national professional associations - orthopaedics, geriatrics, anaesthetics, nursing, psychiatry and physiotherapy, bone metabolism and so on – they can catalyse both training and policy development. Although consensus guidelines, standards and performance measures can be transferred from other nations, they need to be adapted and 'owned' by the specialists in each country where they are to be applied.

Educational strategies can be spread from the international level to the national, but also the converse. For example, in the nursing field, we had the opportunity to organise a course in San Servolo (Italy) in 2016, and, with the help of national experts, during 2017/2018 follow-on courses have been organised in Bologna, Beirut, Athens, Vilnius, Dublin, Berlin, Manchester, Istanbul and organisation of other courses is still in progress. In these courses, nurses had the opportunity to learn from countries with a different nursing approach, to improve their competencies and transfer this new approach to their own clinical context. Similarly, ideas emerging from singular nFFNs can bring new insights to the Global FFN community. For example, for the first time in FFN-Italy, a psychologist has been involved as Board member. This sends a message to global FFN and other nFFNs about the importance of taking care of the psychological aspects of elderly fracture patients, which would significantly improve their recovery.

It is often a challenge to assemble a multidisciplinary audience for educational events. It may be tempting to run the multidisciplinary event alongside a professional association meeting, in the hope that will ensure reasonable numbers at least from that discipline. The problem is that it is then difficult to persuade people from the other disciplines to come to a venue dominated by a discipline not their own. In many cases it may be better to hold an explicitly multidisciplinary event in the name of the national alliance, which may be a nFFN or something equivalent. An example of this approach is the Fragility Fracture courses that were run at the Royal National Orthopaedic Hospital in Stanmore, UK. A programme from one of these events is in the Resources section (page 16).



However, to get the multidisciplinary message across to larger numbers in a given discipline, it may also be useful to have a symposium/session within their professional association meeting and invite speakers to it from the other disciplines.

The role of national FFNs in driving policy change

It is a sad fact of life that, if a professional association tells politicians and health service managers that there is a problem which needs extra resources, it will be assumed that the motivation for making that case is largely self-interest. This is less likely if the case is being made by associations representing several disciplines speaking with one voice. It is even less likely if the alliance has been broadened to include patients, or potential patients – i.e. voters. That is the fundamental value of the national alliance.

In seeking meetings with ministers and managers, it is best to do this in the name of the several professional associations represented, rather than in the name of the nFFN, which has – initially at least – little authority. Therefore, the making of the case to politicians has to be preceded by making the case to the councils or other competent bodies in the relevant national associations, seeking their agreement with the arguments to be put forward. It is essential that the nFFN acquires and maintains the reputation for accurately reflecting the mainstream professional bodies' views.

The case is made much stronger if it is backed up with good quality data, especially that obtained through audit and clinical databases as described in the Projects section. Useful data can often be found in publications like the Regional Audits from the International Osteoporosis Foundation (<http://www.iofbonehealth.org/regional-audits>).

Policy goals

The fundamental goals are common to all – they are laid out in the Global Call to Action: the three clinical pillars of:

- multidisciplinary co-management in the acute phase after fracture, based on orthogeriatric principles and fully involving anaesthetists and nurses
- excellent multidisciplinary rehabilitation, led by geriatricians or physiatrists, connecting seamlessly into post-acute care in the community
- reliable secondary prevention after every fragility fracture, addressing both bone health and falls risk, through a FLS or similar service model

The challenge for the nFFN is to tailor those goals to the circumstances of your country. International meetings like the FFN's Global Congress and Regional Meetings provide an excellent opportunity to get ideas for policy goals and strategies. The Regionalisation section of the global FFN website will showcase stories of successful policy change – please contribute to it as well as learning from it.



Relationship between national FFNs and the global FFN

National FFNs are autonomous organisations, compliant with the law in their own country. However, they are using the name and 'brand' of the global FFN, which expects in return that the nFFN will:

- Commit to the Vision, Mission and Strategic Focus of the FFN
- Commit to a multidisciplinary membership and Board
- Commit to the FFN style of work: integrating existing organisations, not competing with them
- Seek official recognition as a legitimate body in their country
- Raise their own resources locally
- Send a reasonable quota of representatives to each Annual Global Congresses, so that the coherence of the global FFN message is preserved and enriched
- Create a website with links to global FFN website

The global FFN will endeavour to maintain a Board that is balanced by both discipline and global region. So, there will always be some nFFN members on the global Board. However, there is also another route by which the national and global FFNs communicate – the Regionalisation Committee.

The Regionalisation Committee (RegCom)

This is one of the five subcommittees of the global Board – the others being the Scientific, Education, Nominations and Communications Committees. Its chair is *ex officio* a member of the Executive Committee and is directly elected by the General Assembly. The current Terms of Reference for the RegCom are in the Resources section (page 19); however, they are still evolving. The over-arching purpose of the RegCom is to promote the formation of nFFNs and to coordinate their work with each other and with the global FFN. The RegCom will be responsible for the updating of this Guide.

There are already too many nFFNs for each to have a representative on the RegCom. Instead there will be at least one representative from each global region: Asia-Pacific, Latin America, Europe, North America and Middle East/Africa. In each global region, there will be a committee of nFFN Presidents/Chairmen that will choose those representatives and ensure that they carry the views of all the nFFNs in that region to the RegCom.

National FFN websites

National FFNs are strongly recommended to create and maintain a national website; in this day and age, an organisation can barely be said to exist without one. The nFFN will retain full responsibility for the contents of their website; however, it is expected that there will be extensive two-way links between the national and global sites.



Regional FFN meetings

The FFN has no intention of creating standing regional organisations; there will just be national and global levels of organisation. However, it is obvious that occasional (perhaps two-yearly) regional meetings will be valuable in allowing nFFNs to share experience. The nFFNs in a given region should take turns to be the hosts, and the RegCom should oversee the scheduling of the meetings. It is important that the regional meetings do not undermine attendance at the Global Congress. In general, regional meetings should be held in Q1 of the year, the Global Congress in Q3.

Useful resources

A huge array of resources is freely available online which relate to the three clinical pillars of the CtA. Useful examples follow, which will be updated as new resources become available. In addition, the fourth pillar of national FFNs and other national alliances is featured.

Multidisciplinary co-management in the acute phase after fracture

- FFN website: <https://www.fragilityfracturenetwork.org/>
- International Geriatric Fracture Society: <https://www.geriatricfracture.org/>

Multidisciplinary rehabilitation

- Insert Jay's suggestions

Secondary fracture prevention

- IOF Capture the Fracture® Program website: <https://www.capturethefracture.org/>
- Australian and New Zealand Bone and Mineral Society: <http://www.fragilityfracture.org.au/>
- Osteoporosis Canada: <http://fls.osteoporosis.ca/>
- Osteoporosis New Zealand: <https://osteoporosis.org.nz/resources/health-professionals/fracture-liaison-services/>
- National Osteoporosis Society (UK): <https://nos.org.uk/for-health-professionals/service-development/fracture-liaison-services/>



National FFNs and other national alliances

- FFN Japan: <http://ffn.or.jp/>
- SOS Fracture Alliance (Australia): <https://www.sosfracturealliance.org.au/>
- Live Stronger for Longer Alliance (New Zealand): <https://www.livestronger.org.nz/>



Programme for a multidisciplinary national meeting



5th Stanmore Fragility Fractures Course

Programme – Day 1



Wednesday, 30th March 2011

10.00	<i>Registration & coffee</i>	
10.45	Welcome & Introduction	David Marsh
Underlying Science		Chairman Roger Francis
11.00	Cellular mechanisms of sarcopenia	Steve Harridge
11.30	Sarcopenia and the basis for frailty	Finbarr Martin
12.00	Cellular mechanisms of osteoporosis	Graham Russell
12.30	Osteoporosis and the basis for bone fragility	Ken Poole
13.00	<i>Lunch & viewing of exhibition stands</i>	
The multidisciplinary team		Chairman David Marsh
14.00	Acute orthogeriatric care	Helen Wilson
14.20	The surgery of osteoporotic fractures	James Elliott
14.40	The role of the elderly trauma nurse coordinator	Karen Hertz
14.55	Anaesthesia in elderly trauma patients	Stu White
15.10	The role of the General Practitioner	Graham Davenport



15.30 *Afternoon tea & viewing of exhibition stands*

How do we achieve universal secondary prevention in the UK?

16.00	BREAKOUT SESSIONS – 3 x 30 mins (all participants rotate)	
16.30	The NOS campaign	James Cooper
17.00	- Lecture Theatre	Juliette Brown
	FLS models in primary and secondary care	Debbie Stone
	– Seminar Room 1	Mary Elliot
	An FLS Database to match the NHFD	Alastair McLellan
	– Seminar Room 2	David Marsh
17.30	Plenary session to feedback from breakouts	Pam Brown
		Graham Davenport
		Finbarr Martin



5th Stanmore Fragility Fractures Course

Programme – Day 2



Thursday, 31st March 2011

08.30 *Registration & coffee*

Secondary prevention	Chairman	Karen Hertz
09.00	Risk factors for fracture	Roger Francis
09.30	What works in falls prevention?	Mathias Toth
10.00	Current and emerging osteoporosis treatments	Richard Keen
10.30	Current and emerging treatments for sarcopenia	tbc

11.00 *Coffee & viewing of exhibition stands*

11.30 **BREAKOUT SESSIONS**
Either **Primary care**



11.30	<i>Seminar:</i> Osteoporosis-hot topics in primary care (ONJ, atypical fractures, BP compliance, calcium and CVD)	Graham Davenport
12.00	<i>Parallel workshops 1-3:</i>	
	1. How to identify patients at risk and manage them in general practice	
	2. Problem case discussions brought by delegates	Graham Davenport
	3. Vertebral fractures-"the hidden iceberg"	Pam Brown
	- how do we manage them in primary care?	Alun Cooper
	Or (2 rotating groups x 45 min)	
	Group 1 – getting reliable data into the NHFD	Maggie Partridge Andy Williams Fay Plant
	Group 2 – establishing an orthogeriatric service	Helen Wilson Opinder Sahota

<i>13.00 Lunch & viewing of exhibition stands</i>

Policy change	Chairman	Finbarr Martin
14.00 Has the Best Practice Tariff worked?		Rob Wakeman
14.20 The future – BPT and other things		Keith Willett
14.50 Update on the NHFD		Colin Currie
15.10 The international dimension		David Marsh

<i>15.30 Afternoon tea, viewing of exhibition stands and end of course</i>
--



RegCom terms of reference

Regionalisation Committee Terms of Reference

The Regionalisation Committee (RegCom) shall be a standing sub-committee of the Board. Its Chair shall be a voting member of the Executive Committee (ExCom) *ex officio*.

Purpose

The over-riding purpose of the RegCom shall be to promote the formation of national FFNs and to coordinate their work with each other and with the global FFN.

Promotion of new local FFNs

The RegCom will:

- identify countries where there seems to be a critical mass of activists willing to create a national FFN and a local context appropriate for that to be done.
- convince the proposed initiators that they should adhere to the principles laid out in the Guide to National FFN Formation
- ensure that the global, and other relevant national FFNs are aware of developments and provide whatever support is needed for the launch: speakers etc

Guide to National FFN Formation

The RegCom will write a practical guide to the formation of national FFNs and update it as necessary.

The document will cover:

- the need for a multidisciplinary membership and Board
 - examples of constitutions / bye-laws of established national FFNs
- the philosophy of building national alliances to effect policy change
- examples of policy targets and national alliance formats
- the need for the Board members to represent the relevant national professional associations and NGOs (such as Osteoporosis Societies) and to speak with authority on their behalf
- the need for the national alliance to:
 - create consensus guidelines setting clear standards for adequate care using the best available research evidence, and propose metrics to evaluate performance
 - expand education and research programs that can establish best practice
- the principles of the appropriate relationship between the national and global FFN



- the importance of establishing a website for the national organisation, independent but with links to the global FFN website
- the need for legal recognition of the organisation within the country concerned
 - examples of letters/certificates of acknowledgement etc
- the importance of obtaining sponsorship within the country concerned

The Guide will be freely available on the global FFN website.

Relations between FFNs

The national FFN will undertake to send a reasonable number of members to the Annual Global Congress each year, prepared to report their progress both to the RegCom and to the Congress as a whole. These members will pay the registration fee for the Congress, unless they are global Board members or invited speakers, sponsored by their national resources.

Occasional regional meetings will be organised, bringing together national FFNs in the region concerned, to share experience and promote the formation of other national FFNs.

Composition

Chairman

The RegCom Chair shall be directly elected by the General Assembly from candidates nominated by the membership. The term of office shall be two years. Re-election is possible once only.

Regionalisation Manager

The Regionalisation Manager shall be employed – subject to available funding – on a consultancy basis. Selection, commencement and termination of employment shall be decided by the ExCom, on the advice of the RegCom Chair.

Committee members

The membership of the RegCom shall be determined by the Board, on the recommendation of the RegCom Chair. The membership shall be balanced by discipline and global region. The Board may appoint an experienced member as Deputy Chair and Secretary / minute taker, on the recommendation of the RegCom chair. The Deputy Chair may attend ExCom meetings with, or in place of, the chair, as a non-voting member.



Meetings and reporting

The RegCom will meet by teleconference at approximately monthly intervals and face-to-face at the Annual Global Congress. The chair will report monthly to the ExCom and bi-monthly to the Board.

Depending on the agenda and overall situation, the meetings may be joined by the Comms Director, EduCom chair or other ExCom members.

Minutes will be taken and reviewed at the next meeting.

Version of 3 Aug 2018



References

1. United Nations Department of Economic and Social Affairs Population Division (2017) World Population Prospects: Volume I 2017 Revision. New York
2. Cooper C, Ferrari S (2017) IOF Compendium of Osteoporosis. In Mitchell P, Harvey N, Dennison E (eds), 1st edn. International Osteoporosis Foundation, Nyons
3. Cheung CL, Ang SB, Chadha M, et al. (2018) An updated hip fracture projection in Asia: The Asian Federation of Osteoporosis Societies study. *Osteoporosis and Sarcopenia* 4:16-21
4. Dreinhofer KE, Mitchell PJ, Begue T, et al. (2018) A global call to action to improve the care of people with fragility fractures. *Injury* 49:1393-1397
5. Harvey NC, McCloskey EV (2016) Gaps and solutions in bone health: A global framework for improvement. In Misteli L, Laverty C, Stenmark J (eds) World Osteoporosis Day Thematic Report. International Osteoporosis Foundation, Nyon.
6. Australian and New Zealand Hip Fracture Registry (ANZHFR) Steering Group (2014) Australian and New Zealand Guideline for Hip Fracture Care: Improving Outcomes in Hip Fracture Management of Adults. Australian and New Zealand Hip Fracture Registry Steering Group, Sydney
7. Pérez AD, Pérez FF, Erce JAG, et al. (2012) Libro Azul de la Fractura Osteoporótica en España. In Sancho FG, Macías JG, Ogea CC, Benítez PC, Pérez AD (eds). Sociedad Española de Fracturas Osteoporóticas (SEFRAOS), Madrid
8. British Orthopaedic Association, British Geriatrics Society (2007) The care of patients with fragility fracture. 2nd edn
9. Australian Commission on Safety and Quality in Health Care, Health Quality & Safety Commission New Zealand (2016) Hip Fracture Care Clinical Care Standard. Sydney
10. National Institute for Health and Clinical Excellence (2012) Quality standard for hip fracture care. NICE Quality Standard 16. London
11. International Osteoporosis Foundation (2018) Capture the Fracture® Programme website. <http://www.capturethefracture.org/> Accessed 17 October 2018
12. Gittoes N, McLellan AR, Cooper A, et al. (2015) Effective Secondary Prevention of Fragility Fractures: Clinical Standards for Fracture Liaison Services. National Osteoporosis Society, Camerton
13. Johansen A, Golding D, Brent L, Close J, Gjertsen JE, Holt G, Hommel A, Pedersen AB, Rock ND, Thorngren KG (2017) Using national hip fracture registries and audit databases to develop an international perspective. *Injury* 48:2174-2179
14. Royal College of Physicians (2018) The National Hip Fracture Database. <http://www.nhfd.co.uk/> Accessed 17 October 2018
15. Australian and New Zealand Hip Fracture Registry (2018) Australian and New Zealand Hip Fracture Registry website. <http://www.anzhfr.org/> Accessed 17 October 2018
16. Australian and New Zealand Hip Fracture Registry (2018) Annual Report 2018. Sydney
17. Royal College of Physicians (2018) Fracture Liaison Service Database (FLS-DB). <https://www.rcplondon.ac.uk/projects/fracture-liaison-service-database-fls-db> Accessed 17 October 2018
18. Carlson BC, Robinson WA, Wanderman NR, et al. (2018) The American Orthopaedic Association's Own the Bone(R) database: a national quality improvement project for the treatment of bone health in fragility fracture patients. *Osteoporos Int*