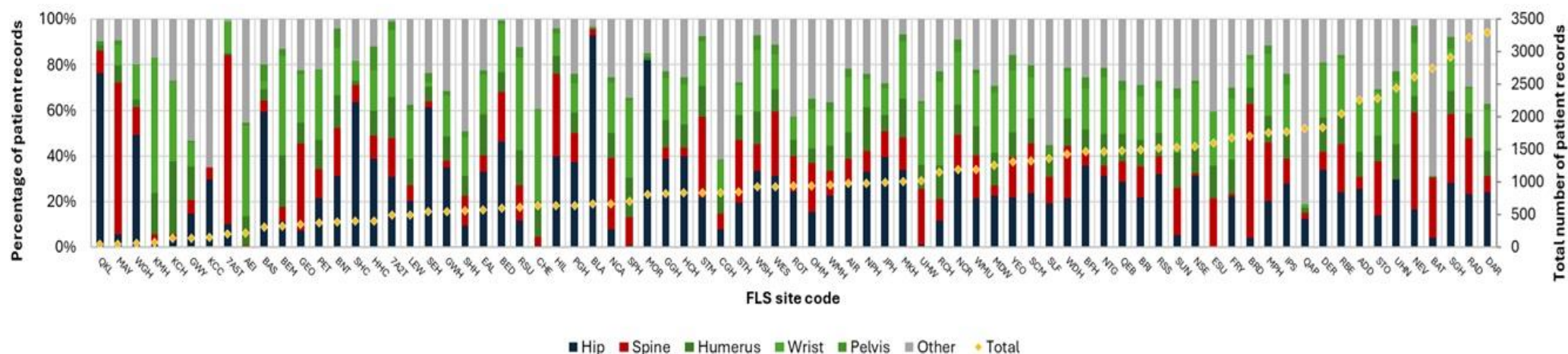


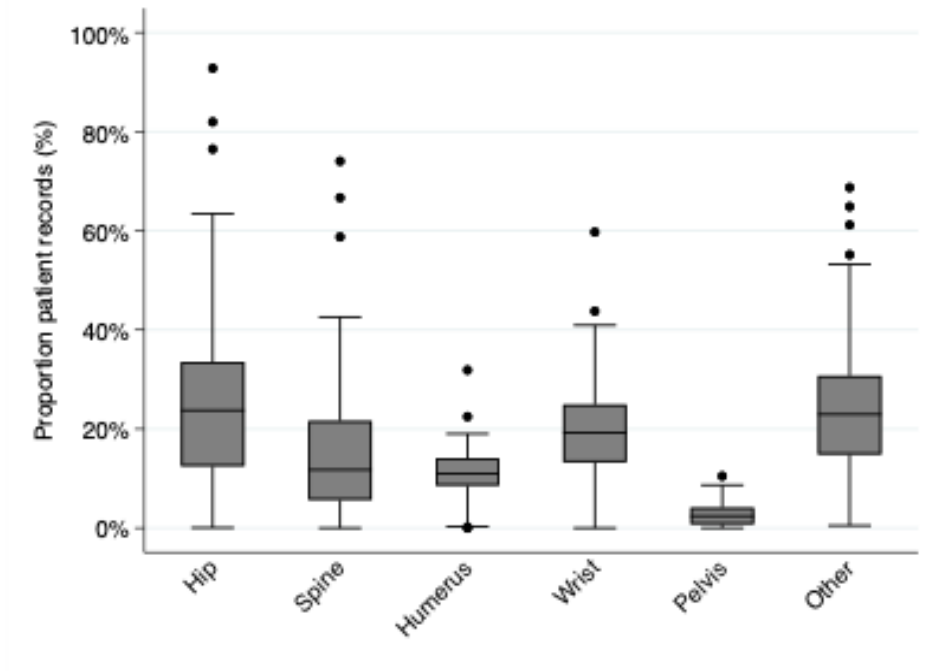
## Fracture Liaison Service Database annual report (2026)

### Steps to fracture liaison service effectiveness: importance of treatment recommendations



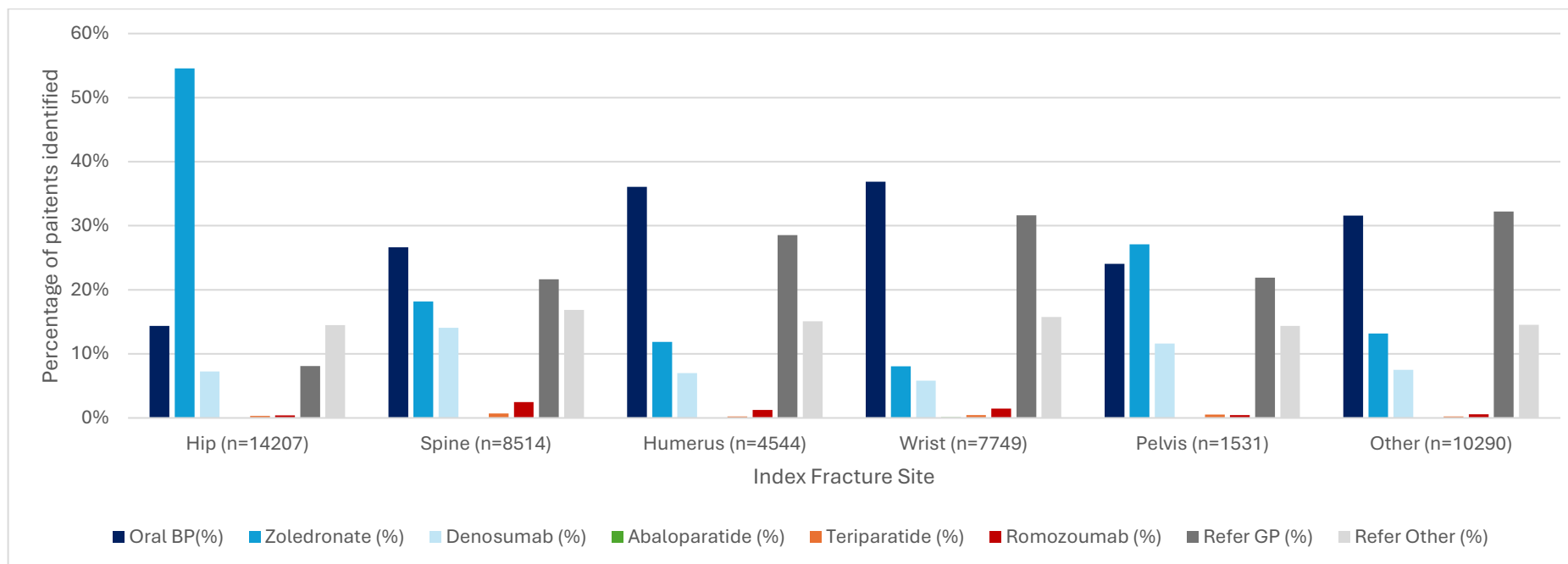
**Fig 1a. Identification rates by fracture site for each participating fracture liaison service**

Fig 1a displays a bar for each participating fracture liaison service (FLS) ordered by the number of patient records submitted in 2024, with the lowest on the left and the highest on the right. The number of patient records in 2024 for each FLS can be seen in the yellow diamonds, using the vertical axis scale on the right. The coloured sections in each bar represent the proportion of hip, spine, humerus, wrist, pelvis and other fractures. The figure highlights the unexplained variability in both the number of cases submitted by FLS as well as the markedly different proportions of each fracture site identified. FLSs are recommended to ensure a higher proportion of their identified patients are from hip, spine, humerus, wrist and pelvis fracture sites, with a smaller proportion of other fractures. FLSs can use this figure to compare their results with other FLSs as part of shared learning and service improvement.



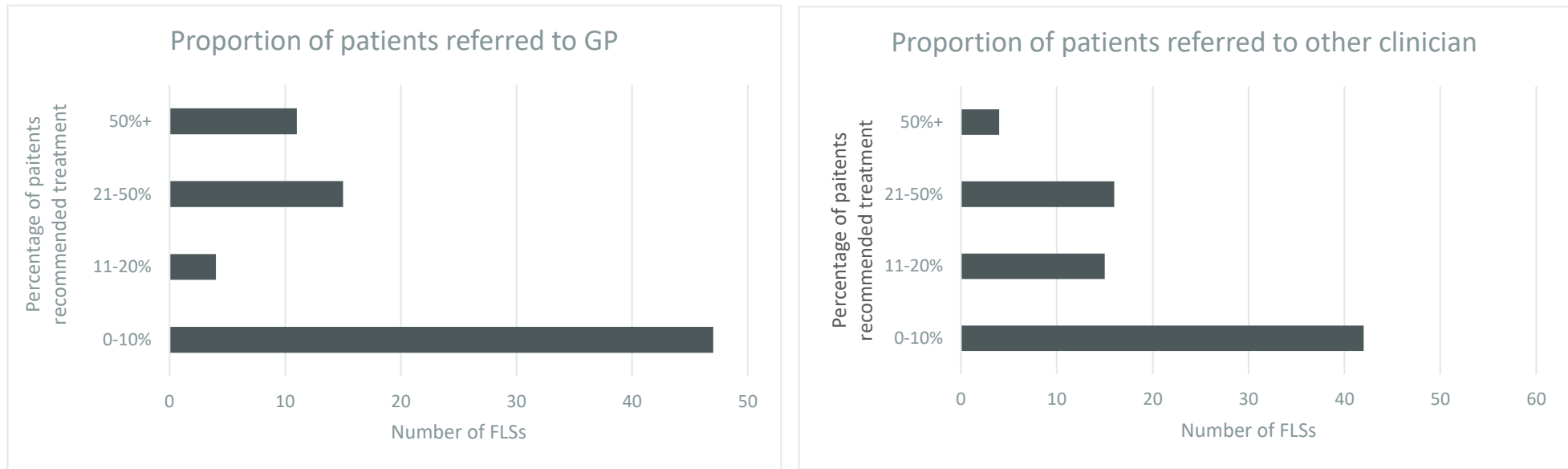
**Fig 1b. Variation in fracture site identification across all FLSs**

Fig 1b shows the proportion of patient records identified by hip, spine, humerus, wrist, pelvis and other fracture sites as the primary fracture site. The proportion of fractures is illustrated in the vertical axis on the left. For each individual bone fracture site, a box and whisker plot show the distribution. The horizontal black line within each grey box is the median/50th centile value. The upper and lower bounds of the boxes represent the 75th and 25th centile values, also known as the interquartile range. The upper and lower whiskers represent 1.5 times the upper and lower centile values with dots representing individual FLSs that exceed this range. The figure shows the significant variability between FLSs, and the proportion of different fracture sites identified. FLSs are recommended to ensure a higher proportion of their identify patients are from hip, spine, humerus, wrist and pelvis fracture sites, with a smaller proportion of other fractures.



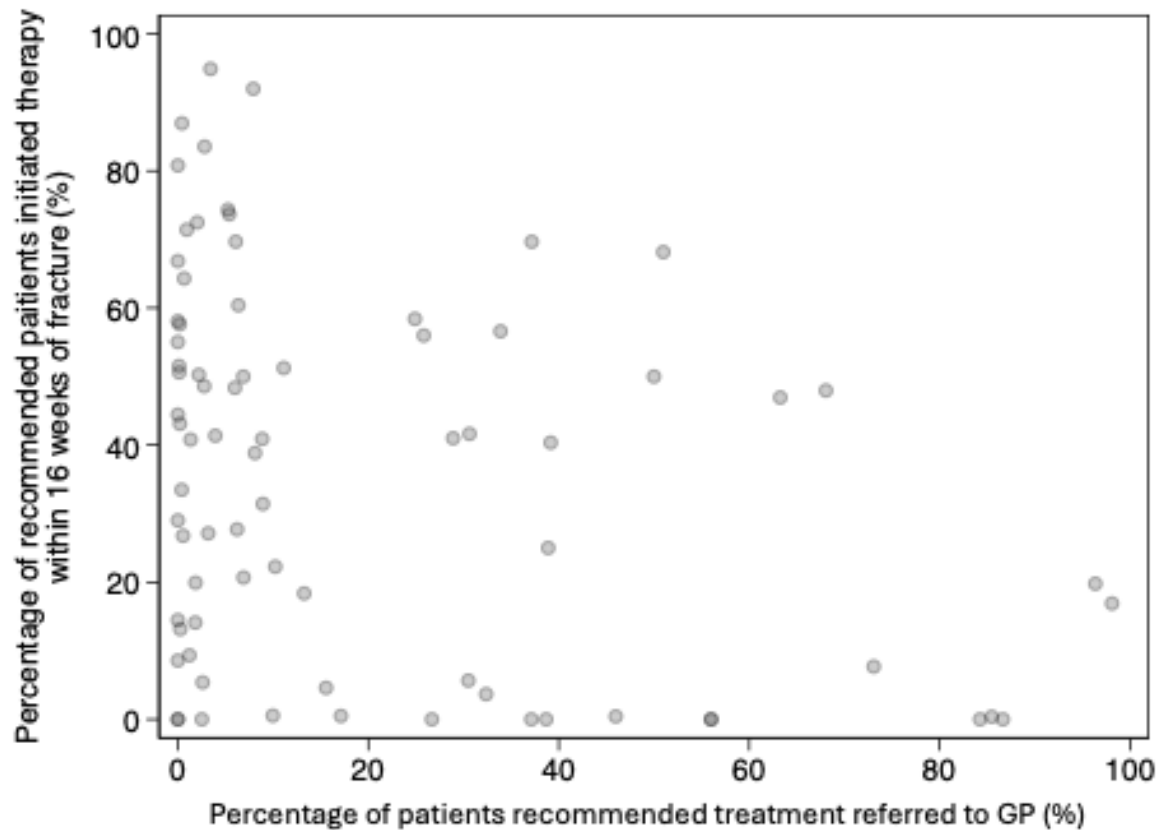
**Fig 2. Bone treatment by fracture site across all FLSs**

Fig 2 shows the different fracture sites and the percentage of patients receiving different types of anti-osteoporosis medication or referred to their GP or other clinician.



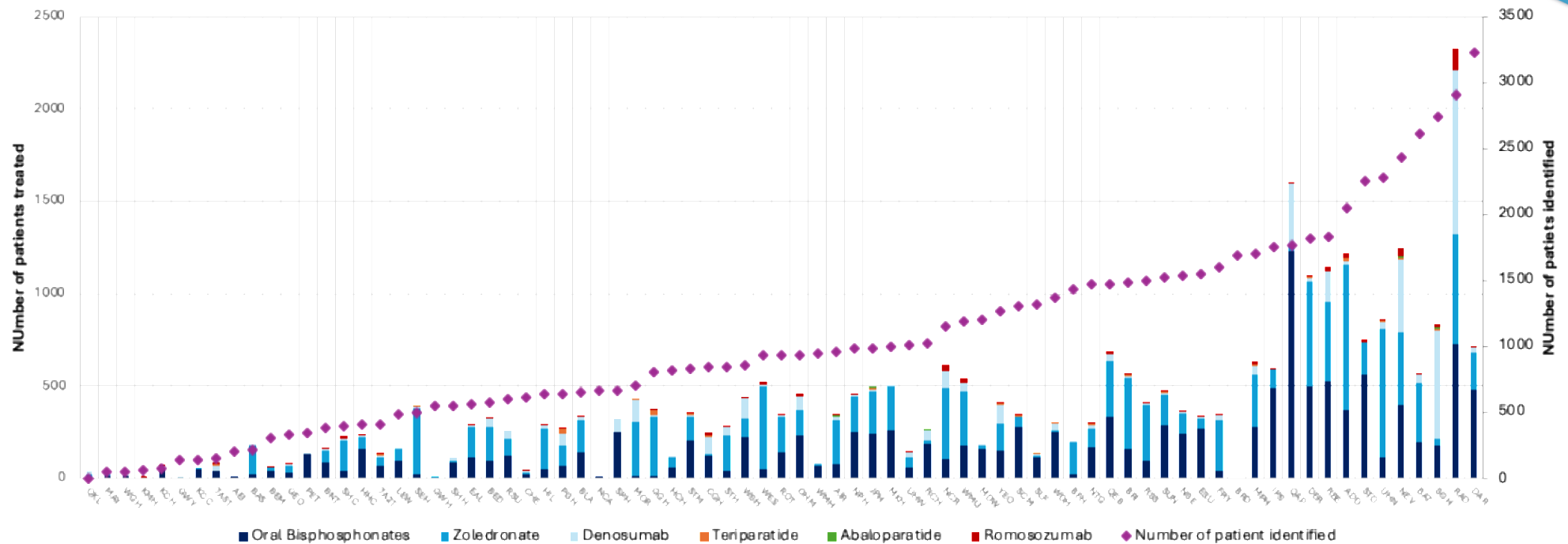
**Fig3. Differences in the percentage of identified patients referred to their GP or other clinician**

Fig 3 shows the number of FLSs that refer different proportions of patients for treatment recommendation to their GP or other clinician. Most FLSs refer 0-19% to the GP or other clinician. However, a small number of FLSs are referring over 50% of the adults they identify to the GP to make the specific treatment recommendation.



**Fig 4. Percentage of patients initiating bone therapy within 16 weeks of fracture if referred to GP for treatment**

In fig 4 each circle in this graph is an FLS and compares KPI 7 – bone treatment recommendation refer to GP with KPI 10 – 16-week treatment initiation. This chart shows that as FLSs refer more patients to their GP for recommended treatment, fewer patients initiate treatment within 16 weeks ( $p=0.009$ ).



**Fig 5. Percentage of patients recommended treatment**

Each column in Fig 5 represents an FLS. The height of the column reflects the number of patients recommended an individual bone therapy. Counts greater than zero and less than five, have been recoded to equal five. This graph demonstrates the variability in the numbers of patients recommended individual bone therapy against the number of patients identified (purple diamonds). FLSs can use this information to compare numbers of patients recommended different types of osteoporosis treatments with FLSs of a similar size.