Fragility Fracture Network

Secondary Fragility Fracture Prevention Competency Framework

Companion Guide for Health Professionals

FFN Secondary Fragility Fracture Special Interest Group (SIG) Advisory Group
May 2025

Acknowledgements

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The FFN SFFP Competency Framework represents the collective expertise, commitment, and international collaboration of health professionals who are dedicated to improving secondary fragility fracture care around the world. Their insights and field-testing were instrumental in shaping a resource that is both practical and globally relevant. We are grateful for their time, knowledge, and unwavering support in making secondary fractures preventable, not inevitable.

SIG Working Group Members

Kim Fergusson	New Zealand
Robyn Speerin	Australia
Brihony Porter	Australia
Wararat Boonnasa	Thailand
Derrick Chan	Taiwan
Maria Diehl	Argentina
Frede Frihagen	Norway
Kassim Javaid	United Kingdom
Sonia Singh	Canada
Jenni Suen	Australia
Peter van den Berg	the Netherlands

SFFP SIG Advisory Group Members

Sonia Singh	Canada
Kim Fergusson	New Zealand
Robyn Speerin	Australia
Gulistan Bahat	Türkiye
Wararat Boonnasa	Thailand
Derrick Chan	Taiwan
Maria Diehl	Argentina
Kassim Javaid	United Kingdom
Tasha Koerner-Bungey	Australia
Juliana Martins Pinot	Brazil
Eligio Razalan	the Philippines
Jenni Suen	Australia
Peter van den Berg	the Netherlands

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Endorsements

FFN gratefully acknowledges the support of the following international and national organisations that have formally endorsed the FFN SFFP Framework and supporting resources.

Their endorsement reflects a shared commitment to improving secondary fracture prevention through consistent, evidence-informed care and the development of a capable, confident global healthcare workforce.

We thank each organisation for recognising the value of this Framework and for championing efforts to reduce the global burden of fragility fractures.

International

- International Society for Clinical Densitometry

Europe

- Royal Osteoporosis Society
- British Society of Rheumatology
- Chartered Society of Physiotherapy
- Norwegian Orthopaedic Association
- Norwegian Society of Endocrinology

Asia-Pacific

- Australian Rheumatology Association
- Endocrine Nurses Society of Australasia
- FFN Thailand
- FFN Taiwan
- Fracture Liaison Network of New Zealand
- NSW Agency for Clinical Innovation, Australia
- The Taiwanese Osteoporosis Association

North America

- Osteoporosis Canada

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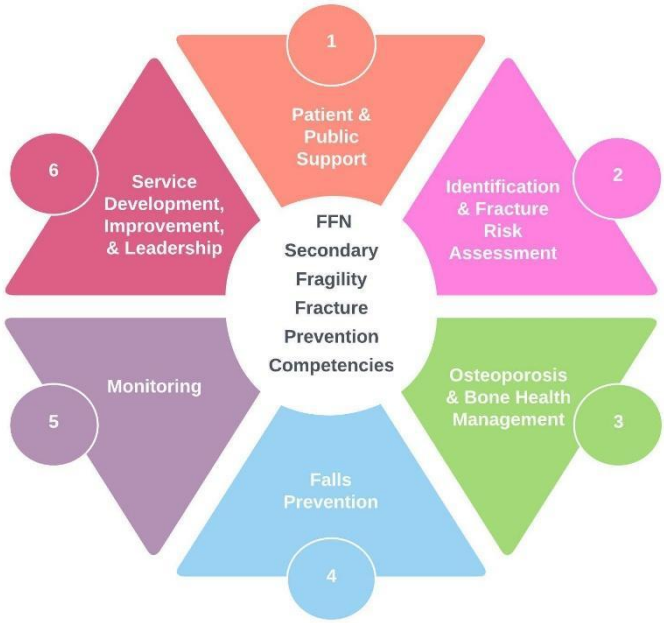
Introduction

The aim of this Companion Guide is to provide additional information about each competency listed in Fragility Fracture Network (FFN) Secondary Fragility Fracture Prevention Competency Framework (FFN SFFP Framework). It will help each health professional using the Framework to figure out if they are ‘competent’, ‘proficient’ or an ‘expert’ in each competency. This will allow them to find out what their personal learning needs are and develop a plan of training and education to become more efficient in providing secondary fragility fracture prevention care to patients.

FFN SFFP Framework can be used in a variety of healthcare settings, including hospitals and community services, and public, academic, or private practices. It is intended to be used by any discipline that is involved in the care of people who sustain fragility fractures.

The FFN Secondary Fragility Fracture Prevention Special Interest Group Advisory Group (SIG Adv Grp) has organised the competencies into three levels of experience; however, we recognize that some local health services may not be able to provide all aspects of care for each competency. Please focus on those that are most relevant to your work/ service model.

Following successful implementation globally, the SIG Advisory Group intends to complement this Framework with additional resources that meet the needs of beginner health care professionals, caregivers, and others.



Glossary of Terms

Term	Definition
Atypical femoral fracture	Minimal trauma or no trauma fragility fractures of the femur between the lesser trochanter and distal femur associated with anti-resorptive drug use and further classified by American Society for Bone and Mineral Research (ASBMR) criteria.
Balancing measure	A measure of the FLS service performance that should not worsen after implementing a change in service, e.g. by improving identification of people who have sustained a spinal fracture; the time to DXA does not deteriorate.
Clinical Osteoporosis	Refers to a diagnosis of osteoporosis that is based on the occurrence of one or more fragility fractures, regardless of the patient's bone mineral density (BMD).
Driver diagrams	A visual tool that shows how a goal can be achieved. It helps teams plan and understand the steps needed to make improvements.
DXA	Dual Energy X-ray Absorptiometry, a low dose X-ray based method to measure bone density, usually at the lumbar spine and proximal femur.
Fishbone	A graphical tool to show the relationships between causes and effects or actions and outcomes, that helps teams identify areas for improvement.
Fracture risk tools and findings	These are validated tools that estimate the risk of another fracture based on patient details. e.g. FRAX or Garvan. They are available on-line and require input of risk factors to gain an understanding of an individual's risk of fracture over certain time periods.
Fragility fracture	A fracture from minimal trauma such as a fall from standing height or less.
Health professionals	The term used to refer to all professionals trained and experienced in providing healthcare to patients, their families and carers. Inclusive of medical and surgical doctors, nurses and allied health professionals.
Health promotion	The process of enabling people to increase control over, and to improve their health status.
KPIs	Key Performance Indicators.
Non-pharmacological therapies	Activities or treatments that have been shown in research studies to be of benefit in prevention of fragility fractures and/or falls.

Osteoporosis	A skeletal disorder characterised by decreased bone mass and deterioration of bone microarchitecture, leading to increased bone fragility and a higher risk of fractures.
Osteoporotic Vertebral fracture	A fragility fracture of a vertebral/spinal bone.
Quality Improvement (QI) cycle	A formal process to analyse current practice, develop, implement and evaluate changes, to inform the requirements that will improve the effectiveness, efficiency and patient experience of healthcare systems. Often referred to as the Plan, Do, Study, Act (PDSA) cycle.
Regional/National clinical FFN networks	Fragility Fracture Network (FFN) is set up to have a Global overarching membership but also divided into regions of the Globe. Each region meets regularly with the National FFNs to provide more localised education and other opportunities that are aligned with local healthcare provision and population customs.
Sarcopenia	A condition characterised by the progressive loss of skeletal muscle mass, strength, and function, typically occurring with age. Can be linked with natural aging, but also with other factors like malnutrition, inactivity, and certain medical conditions.
Scalable interventions	A change or solution that works well in one place and can be successfully expanded to work in other locations or on a larger scale.
Secondary fracture prevention service	Any healthcare service or practice that identifies adults aged 50 years and over who have sustained a fragility fracture to assess their fracture risk, recommend anti-osteoporosis treatment, falls prevention, and other lifestyle interventions and then monitor patients for at least 12 months to ensure these interventions are initiated and continued or adjusted as required to improve bone health.
Secondary Fragility Fracture Prevention	Strategies and interventions aimed at preventing additional fractures in individuals who have already experienced one or more fragility fractures, particularly those related to osteoporosis.
Spreadable intervention	A service change with learnings that are useful to the wider community.
Stakeholders	Any person or group with an interest in or that may be affected by the service.
Sustainable interventions	Treatments that deliver best health outcomes for patients with minimal financial, social and environmental costs and ensures long-term effectiveness and benefits.
Validated falls risk assessment tools	Tools that are used to assess an individual's risk of falling. Recommend those listed in the World Falls Guidelines at https://worldfallsguidelines.com/ .

Competency Framework Guidance

To use the Competency Framework Guidance, locate the relevant competency number in the left-hand column. Use the corresponding guidance on the right to understand its intent, context, and examples of application in practice.

Key: C = Competent, P = Proficient, E = Expert

Competency 1: Patient and Public Support

Competency		Guidance
1	**C1** Explains osteoporosis and fragility fractures to patients and the public, using language and resources they understand.	This competency is self-explanatory and focuses on effective communication tailored to the audience.
1	**C2** Seeks advice from senior clinicians when capacity and consent issues are complex.	Refers to the cognitive capacity of the patient and consent for treatment.
1	**P1** Plans and implements educational strategies (within their own service) for improvement of bone health and prevention of fractures for individuals and groups.	This includes selecting appropriate tools and methods to share information with people receiving care, their carers, families, and the broader community. It is important to consider using a range of communication methods appropriate to your service, including phone calls, online chat, or other locally accepted formats. At the Proficient level, these strategies are implemented within your local service or team.
1	**P2** Acts as a resource for information about local and national support services.	E.g. People approach you to provide them with expertise about what is available locally and nationally for people with fragility fractures.
1	**P3** Develops and evaluates local patient information resources and seeks patient feedback.	Feedback helps make sure the information stays useful, clear, and meets the needs of people receiving care, their carers, families, and the community.
1	**P4** Incorporates co-design principles in the development of resources.	E.g. when developing a resource, you seek input from others such as people seeking the care, their carers and families who can contribute to the accuracy of content information, appropriate

		level of wording for the intended audience.
1	**E1** Educates other health professionals and participates in regional/national clinical networks to share knowledge and expertise.	This competency reflects active leadership in professional education and knowledge exchange beyond the local service level.
1	**E2** Plans and implements educational strategies for improvement of bone health and prevention of fractures for individuals and groups at regional and national levels.	This is like P1, but at a regional / national level.
1	**E3** Ensures that the language of printed publications reflects the needs of local ethnic groups.	Uses words and phrases that are respectful, clear, and relevant to the cultural and language needs of local ethnic groups. This helps ensure that all patients and communities can understand and feel included in healthcare messages.
1	**E4** Leads the development of patient information resources in different formats.	This is different from proficient level in that you take leadership and expand available options for your own service and others.

Competency 2: Identification and Fracture Risk Assessment

Competency		Guidance
2	**C1** Identifies and refers patients with fragility fractures who require secondary fracture prevention assessment.	E.g. You have the skills to identify which patients require SFFP.
2	**C2** Assesses fracture risk according to local guidance and standard tools e.g., FRAX, Garvan found at https://www.fraxplus.org/calculation-tool and https://www.garvan.org.au/research/bone-fracture-risk-calculator .	Resources and tools available may vary depending on local / regional guidelines and resources. Resources available should be maximised. May range from questioning regarding risk factors, to fracture risk calculation tools, to DXA, blood tests, etc. In consideration of potential for undiagnosed vertebral fractures use spine x-rays or Vertebral Fracture Assessment (VFA) where available. See Lems et al (2021) in the reference list resource document.

2	**C3** Evaluates treatment adherence and self-management for people who are being treated for osteoporosis and have a fracture while on treatment.	This assumes this is a step in your service provision. For example – may be provided by a primary care provider or SFFP service. This may include factors such as prescriptions dispensed, discussion with patients on frequency and method of administration, bone turnover markers (where utilised).
2	**C4** Discusses with patients/carers the relevance of fracture risk tools and findings.	Can adjust their way of explaining fracture risk results to ensure the people seeking care and their carers/families understand the significance. Such as low, high and very high fracture risk. This may vary with patient literacy, education, culture, etc.
2	**C5** Assesses the risk of non-accidental injury as part of elder abuse where appropriate.	This is important as non-accidental injury is underreported in older individuals. This could include domestic abuse as well as elder abuse.
2	**C6** Assesses dietary calcium intake.	Assessing the number of 'servings' of dietary calcium consumed by the person seeking care in consideration of the recommended servings in local dietary guidelines. Requires general knowledge of calcium content in various food sources. See the FFN resources regarding nutrition on the FFN Website
2	**P1** Contributes to development of local guidelines for assessment and investigation.	E.g. working with a cross specialty and disciplinary local group to provide your expertise in the development of local management guidelines for SFFP services and practitioners. Should be based on national guidelines and resources if available. If no national guidelines, default would be to use international guidelines sources such as FFN/ IOF.
2	**P2** Recognise the features of an atypical femoral fracture.	This includes aspects of the history and radiology.

2	**P3** Undertakes pain assessment for vertebral fractures.	This includes potential symptoms of vertebral fractures, examination findings and previous treatments (medicinal and non-medicinal) such as heat packs, cognitive behavioural approaches. Can identify features of acute versus chronic pain.
2	**P4** Undertakes additional detailed assessment to further understand individual bone health including assessment/examination for other comorbidities related to osteoporosis and its management.	E.g. a good health history. This includes exploring potential secondary causes of osteoporosis (e.g. steroids, rheumatoid arthritis, inflammatory bowel disease, malabsorption, liver diseases, diabetes, myeloma etc.). This may include relevant blood tests, review of relevant imaging.
2	**P5** Interprets findings of risk assessment and plan next steps in diagnosis/ management/prevention of fragility fractures.	This highlights the importance of using assessment results to inform clinical decision-making and care planning.
2	**E1** Ensures the latest clinical guidance regarding bone health assessment becomes part of normal practice.	E.g. understand concepts of literature review and discerning evidence that may be included in local clinical pathways. Is also cognisant of the launch of international and national guidelines, all of which may be included in local clinical pathways for the local patient group.
2	**E2** Engages with local stakeholders to develop local patient identification and referral pathways for secondary fracture prevention.	E.g. may include electronic tools, standard/ automatic referrals, setting up of automated lists, establishing communication with relevant departments and services including primary care and other private practitioners.
2	**E3** Contributes to regional and national guidelines for assessment.	This reflects active involvement in shaping broader standards of care beyond the local level.
2	**E4** Advises on assessment findings in complex cases.	This may be directly with the patient or as a resource for other colleagues.

Competency 3: Osteoporosis and Bone Health Management

Competency 3.1 Lifestyle change – the 'how'

This Competency refers to **how** interventions should be delivered to gain the best possible outcomes.

Competency		Guidance
3.1	**C1** Engages with the patient or carer to discuss lifestyle and behaviour changes required to improve bone health.	Discusses with the patient/caregiver lifestyle changes e.g. food intake/exercise regimen (plan)/smoking cessation/alcohol intake/and others; in a manner that encourages shared decision making, planning, implementing and review. Personalised recommendations based on the patient's current lifestyle behaviour and beliefs.
3.1	**C2** Understands and discusses with the patient or carer any barriers that may exist to self-management and lifestyle changes to support improved bone health.	In a manner as per C1.
3.1	**C3** Refers to appropriate specialist services for lifestyle change support.	E.g. referring to other service providers in or outside your health service as determined appropriate for example smoking cessation and other lifestyle risk factor modification support.

3.1	**P1** Educates other healthcare professionals on behaviour change and implementation.	Has completed evidence-informed training on behaviour change and healthy lifestyle approaches and applies this knowledge in clinical practice. Able to support others through train-the-trainer models. Examples of behaviour change training can be on-line courses, literature reviews especially multipart series from experts.
3.1	**E1** Develops and implements strategies for health promotion and lifestyle change and involves other staff in implementing these.	The expert practitioner undertakes P1 but also develops the service delivery protocols to reflect integration of behaviour change approaches. This is done in collaboration with other team members for delivery of health

		promotion and lifestyle change strategies.

Competency 3.2 Non-pharmacological therapies – the 'why'

This Competency refers to **why** interventions should be delivered to gain the best possible outcomes.

Competency		Guidance
3.2	**C1** Explains to patients/carers the aims and general value of non-pharmacological strategies such as diet, smoking cessation, alcohol consumption and exercise related to bone health.	Understands and can convey to pts/carers as to why these non-pharmacological strategies are so important. This includes using shared decision-making techniques.

3.2	**P1** Personalises recommendations regarding dietary and supplemental calcium and vitamin D intake based on the patient's needs.	Can take the explanation as per C1 and take it a step further and can discuss and support implementation based on an individual's needs and in consideration of local practices and guidelines.
3.2	**P2** Personalises recommendations for evidence-based exercise regimens.	Is competent and understands how to prescribe appropriate levels of exercise regimens (physical activity plan) based on an individual's health and social conditions, and available resources to help deliver and monitor exercise recommendations.
3.2	**E1** Develops and manages referral pathways to other services in line with local / regional/ national best practice.	This reflects the ability to design and maintain effective referral processes that support integrated care.
3.2	**E2** Monitors referrals to other therapies/services and outcomes of these.	This highlights the importance of follow-up to ensure referrals lead to appropriate and effective care.

Competency 3.3 Pharmacotherapy

Competency		Guidance
3.3	**C1** Explains (according to local guidance) to patients/carers the benefits, and method of administration of first-line anti-osteoporotic medications.	This includes using shared decision-making techniques.
3.3	**C2** Provides appropriate supporting information in a relevant format.	E.g. consider the patient's level of literacy, language, culture. Plus, their personal perspective on how they are best able to learn e.g. one-on-one or group interventions; electronic or paper-based options.
3.3	**C3** Recognises barriers to treatment adherence and discusses these with patients/carers.	Understands common misconceptions regarding treatment regimens (plan), can problem solve in collaboration with the patient/carer. Knows when the support of more proficient/expert colleagues are required to support decision-making. Know your scope and your limitations.
3.3	**C4** Informs patients/carers about recognizing and acting on common side effects.	Considers common side-effects and leaves less common and harmful side-effects to more proficient and expert colleagues.
3.3	**C5** Provides patients/carers with contact information to seek further advice and support.	This ensures individuals know where to seek additional help or information.
3.3	**C6** Advises patients/carers about patient groups if available.	This promotes access to peer support and community resources.
3.3	**C7** Is aware of what medications are available and helps patients to navigate funding options.	Understands what medication types are available in your country. Is aware of funding criteria for medication types. Aware of, and if allowed in your country, alternate self-funding options to access clinically appropriate medications.
3.3	**P1** Educates local staff about newly approved treatments and relevant clinical updates for existing treatments.	This will include any health professional working with people who require secondary fragility fracture prevention. Those within and outside your health service or practice site.

3.3	**P2** Explores and discusses full treatment options with patients/carers.	This emphasises the importance of shared decision-making and informed consent in care planning.
3.3	**P3** Describes the anticipated fracture reduction following treatment.	Can communicate the fracture risk associated with and without medication treatment.
3.3	**P4** Makes recommendations for treatment changes as appropriate, seeking advice from senior clinical staff as required as permitted by national or local regulations.	This reflects the importance of clinical judgement, collaboration, and regulatory compliance when adjusting treatment plans.
3.3	**P5** Describes potential less common and rare side effects from treatments locally available.	Such as osteonecrosis of the jaw (ONJ), atypical femoral fracture (AFF), severe hypocalcemia, uveitis.
3.3	**P6** Evaluates and manages less common and rare side effects of treatment, undertaking/ arranging further investigations/referrals as permitted by national or local regulations.	Has a clear understanding of the needs of this patient group in collaboration with other team members e.g. other medical specialists.
3.3	**P7** Informs the primary care physician and other relevant stakeholders about the treatment recommendations.	In addition to having a proficient understanding of patient needs and treatments, this level of competence will understand how to deliver treatment plans to the other members of the patient care team.
3.3	**P8** Advocates for policy change regarding medication funding.	Has input to discussions concerning policy changes as required for the patient group at a local, regional or national level.
3.3	**E1** Ensures the latest local clinical guidance regarding bone treatments become part of normal practice.	This includes reviewing local pathways of care to ensure they reflect additions or deletions in regional or national guidelines. Advocates for updates of local pathways of care when needed.
3.3	**E2** Informs regional or national treatment pathways.	Actively participates in the regional or national pathways of care.

Competency 4: Falls Prevention

Competency		Guidance
4	**C1** Undertakes falls risk assessment (in line with local guidance) for all patients with fragility fractures resulting from a fall.	As per Global Falls guideline at World Falls Prevention Guidelines.
4	**C2** Uses validated falls risk assessment tools and works within local and national protocols.	The validated tools listed in the Global Falls guideline or local protocols.
4	**C3** Explains outcomes of screening to patients/carers and discusses individual needs.	While many outcomes are clear on what may be suggested to the patient for consideration of implementation, the Competent health professional will at times need to seek guidance from a proficient or expert colleague.
4	**C4** Recognises causes of falling that require urgent evaluation.	*Refer to your local falls protocols to understand what to look for regarding urgent evaluation. Examples are hypotension that could be related to medication regimen; hypoglycaemia especially in the person with Type 1 Diabetes Mellitus (TIDM) or Type 2 Diabetes Mellitus(T2DM); and neurological symptoms.
4	**C5** Provides fall prevention interventions (within scope of practice).	Refer to your local protocols.
4	**P1** Appropriately refers patients for ongoing specialist multifactorial falls assessment and intervention based on regional, national or international guidelines such as the World Falls Prevention Guidelines .	This competency is self-explanatory and identifies patients at risk and ensures timely referral to appropriate services in accordance with best practice.
4	**P2** Educates other healthcare professionals about falls prevention.	This competency is self-explanatory and promotes high-quality care by ensuring colleagues are informed of current best practices in falls prevention.
4	**P3** Has basic understanding of physical activity programs for prevention of falls and optimizing bone health.	Understands the evidence base for different physical activity programs.

4	**E1** Develops and improves multidisciplinary assessments and care pathways for falls prevention for secondary fracture prevention services based on regional, national or international guidelines, such as the World Falls Prevention Guidelines	This competency is self-explanatory and embeds evidence-based falls prevention into standard care processes to reduce the risk of future fractures.
4	**E2** Develops tailored physical activity programs to address falls prevention needs.	In consideration of an individual patient with their own specific comorbidities and desire to undertake any specific activity.

Competency 5: Monitoring

Competency		Guidance
5	**C1** Monitors treatment adherence, side-effects and contra-indications to locally available medications.	Understands the key components for checking that medications are used as expected including how they are taken, frequency and common side effects. Understands behaviour change in consideration of supportive and collaborative interactions to aid adherence.
5	**P1** In collaboration with patients, family and/or carers makes recommendations for bone treatment changes as appropriate, seeking advice from senior clinical staff as required and as permitted by national or local regulations.	This includes shared decision making based on their beliefs and health literacy.
5	**P2** Interprets repeat DXA results to identify clinically relevant differences.	Refer to previous DXA results of individual patients. Refer to International Society of Clinical Densitometry (ISCD) at https://iscd.org/ for what constitutes 'clinical relevant difference' and least significant change (LSC).
5	**P3** Provides alternative medication treatment regimen to reinforce adherence.	E.g. considering a change from oral to injectable medication.
5	**P4** Interprets laboratory results to identify clinically relevant differences.	E.g. bone turnover markers.
5	**E1** Leads the development of local pathways to monitor patient recommended treatments and other interventions that reduce fracture risk such as falls prevention.	This competency is self-explanatory and ensures patients receive appropriate ongoing care to minimise future fracture risk.

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Competency 6: Service Development, Improvement, and Leadership

Competency		Guidance
6	**C1** understands and follows the basic steps of a Quality Improvement (QI) cycle.	Understands the Plan Do Study Act (PDSA) known in some areas of the globe as Plan Do Check Act (PDCA) cycles.
6	**C2** Understands Local Referral Pathways.	How to access all the services or health professionals that the person/carer needs outside of your own practice setting. Contributes to the list of service providers you may encounter and liaises with more senior team members for possible additions to the Local Referral Pathways.
6	**C3** Undertakes evaluation of patient experience to inform care delivery.	Understands 'patient experience' as versus satisfaction surveys. Examples could include 'did the service consider my needs concerning where, how and when I received the service'. Use of open-ended questions concerning identified experiences.
6	**P1** Monitors and audits performance of services and outcomes against key performance indicators (KPI).	Utilises service data concerning KPIs to consider changes for service provision with the service team.
6	**P2** Designs the key components of a QI cycle in collaboration with secondary and primary care providers.	Includes all related service providers in planning identified and needed service changes/improvements. Collaboratively determines the QI cycle components at the outset and as the cycle progresses.
6	**P3** Leads the QI cycle.	Guides a structured process aimed at enhancing healthcare practices, systems, or outcomes.
6	**P4** Completes fishbone and driver diagrams.	Lists all the contributors to the patient care journey and/or service delivery processes, to identify areas for improvement.

6	**P5** Identifies process, outcome and balancing measures.	Selects appropriate indicators to monitor the effectiveness, impact and outcomes of quality improvement activities.
6	**P6** Describes the key components for a sustainable, scalable, and spreadable intervention.	Uses Lean principles available at https://theleanway.net/The-Five-Principles-of-Lean Spread results of Quality Improvement with positive outcomes. Begin with small scale implementation with rapid cycles and spread to other services.
6	**P7** Undergoes professional development to become a better trainer (train the trainers).	Builds skills and confidence to educate others by engaging in relevant training and reflective practice.
6	**P8** Provides training locally for healthcare professionals in other specialties as well as the coordinated secondary fracture prevention services.	Sharing learnings with local colleagues e.g. across wards, outpatient clinics, private/community/primary care settings.
6	**E1** Can present the entire QI cycle local, regionally and nationally.	Communicates QI processes, outcomes and learnings clearly to diverse audiences to support knowledge sharing and wider adoption of best practices.
6	**E2** Participates in and contributes to embedding up-to-date research and evidence for quality improvement and fracture prevention.	Supports the integration of current evidence into practice to enhance care quality and outcomes.
6	**E3** Provides training for healthcare professionals in other specialties as well as the coordinated secondary fracture prevention services at a regional and/or national level.	Shares expertise to build capacity across disciplines and promote consistent, evidence-based care.
6	**E4** Shares experience and expertise with peers locally, regionally and nationally.	In all efforts utilise the principles of Adult Learning Theory. Planning and delivering workshops locally, regionally and nationally. Sharing learnings with other private and coordinated services at e.g. conferences, journal articles.
6	**E5** Leads quality planning for service development.	Drives strategic planning to improve service delivery, ensuring alignment with quality standards and patient needs.

6	**E6** Develops pathways and engages partners for referrals outside of the secondary fracture prevention service.	Establishes effective referral processes and collaborates with external services to support patient centred care.
6	**E7** Contributes to reviews of other services and national guidance on fracture prevention.	Actively seeks out opportunities to contribute to improved service delivery regionally, nationally and internationally. Contributes to efforts to improve services as is required and determined by those in authority.
6	**E8** Provides data/ information to non- clinical decision makers at regional or national level.	Has a clear understanding of service needs as identified by data and other information sources. Has the ability to convey this data/information to non-clinical decision makers in language that makes sense for them.
6	**E9** Supports and advocates for policy changes.	Promotes and takes action to improve services, guidelines or systems. Promotes policy changes related to service commissioning and access to osteoporosis medications and other therapies.

Frequently Asked Questions

1. Will I receive a certificate of competency following the completion of this self-assessment?

No, this is a self-assessment tool to help you reflect on your current level of competency and which elements of competency in secondary fragility fracture prevention you may need to further develop. You may wish to seek feedback from your colleagues to supplement your self-assessment. You may also want to use the outcomes of your self-assessment and further competency development needs in discussions with your manager or supervisor.

2. What resources can I use in efforts to increase my knowledge and expertise in fragility fracture prevention?

Start local, then regional, then national, and finally global such as the International Osteoporosis Foundation (IOF) and Fragility Fracture Network (FFN) for resources such as clinical guidelines. You may also like to review the reference list posted on the FFN resources web pages.

3. Are these Competencies only for formalised and coordinated SFFPSs?

No, the Competencies are for any health professional no matter their designation or profession in any care setting. The care settings could be in a hospital, outpatient clinic, or in private rooms such as primary care physicians' rooms, physiotherapist clinics, aged care settings - residential or full care.

4. Do I have to meet all the competencies at one level before I move on to the next level?

No, you may find you have a range of competency levels within each of the 6 competencies.

5. Why isn't early intervention to reduce risk of osteoporosis included, before a person sustains a fragility fracture?

This Competency Framework is focused on working with people who have already experienced a fragility fracture. If this Competency Framework is a success, that it is found to be useful for health professionals working with people who have already had a fracture, the FFN may proceed to undertake more competency sets. People who have experienced fragility fractures and have helped inform this current set of competencies have asked that we also develop a set for competencies for them. This may also be a part of future work.

6. Why is there not more detail in each competency?

The competencies are intended for use across the Globe. For this reason, the competencies had to be brief to allow for local interpretation. The detail specific to your country / region will be influenced by your local guidelines, resources, and scope of practice.

7. What do we mean by 'behaviour change'?

In this set of Competencies, 'behaviour change' refers to the approach taken in all interactions with people who have experienced a fragility fracture, as well as their carers and families. It emphasises working *with* patients as partners in their care.

Secondary fragility fracture prevention is a **chronic care intervention**. This differs from **acute care**, where decisions are often made quickly by the healthcare team and patient involvement is limited. In chronic care, success depends on meaningful collaboration with patients and carers.

This means:

- Talking with the patient or carer about their health condition
- Exploring different treatment options and explaining the reasons for each
- Jointly deciding how to carry out the chosen treatment in a way that is both safe and effective

When patients are involved in shaping their care, they are more likely to follow through with the plan and share feedback on how it's working. This helps reduce treatment failure and supports long-term engagement in their own health.

Because bone health care is a lifelong journey, health professionals need to understand and respect the patient's beliefs, motivations, and concerns. This leads to better outcomes than simply instructing patients on what to do.

To begin learning about behaviour change, you might want to explore some of the foundational theories developed in psychology, nursing, and related fields. Here are two helpful starting points:

- Behavioural Change Theories – Boston University School of Public Health
- "A scoping review of behaviour change theories used in interventions targeting musculoskeletal health" – PubMed

Applying behaviour change principles in your daily practice can take time. Consider it an ongoing journey as you explore what works best for you and your patients.