Exploring the Welsh approach to managing osteoporosis reveals fundamental differences compared with England, Scotland and Northern Ireland, not only in the demography but also in organisational structures that influence how health services are delivered in the principality. These differences are examined by reviewing the literature and through informal discussions with health professionals and patients.

A future of hip fractures?
Three-quarters of the 2.94 million population of Wales live around the mining valleys and large cities of the south-east and 21% of the population are over retirement age. Since 1971, Wales has experienced a 30% increase in the number of people of retirement age and it has the highest percentage of the population ≥65 years of age, compared with the rest of the UK. Wales is predicted to be the UK country with the largest projected proportion of the population of pensionable age for the year 2031 at 24.4%. Many Western nations have acknowledged hip fracture in older people due to osteoporosis as a major public health problem; Wales must address this issue.

The NHS in Wales
The NHS Wales receives its allocation for services as a part of a ‘block grant’ to the National Assembly for Wales (NAfW) through negotiation with Westminster. The NAfW is the elected body that represents the interests of the Welsh population and holds the Welsh Assembly Government (WAG) to account. Where osteoporosis services have been successfully developed, clinicians believe that accessibility to individual assembly members has been useful in raising awareness of osteoporosis and driving services forward. The WAG is responsible for many issues of day-to-day concern, including health, and it abolished prescription charges for all Welsh residents in 2007. Adherence with bone protective therapies is recognised to be suboptimal and it would be interesting to determine if free prescriptions influence adherence! The WAG has set the current referral target of ten weeks for outpatient appointments, and clinicians report that this affects the organisation of osteoporosis clinics and has a knock-on effect on waiting times for diagnostic measures such as dual-energy X-ray absorptiometry (DXA) scans. Provision of DXA scan units has improved but remains patchy, with seven units in the south, one in mid- and one in north Wales. DXA scan waiting times range from three weeks to six months but the WAG does not ask for these to be reported; services may have a higher profile if such data were submitted. Clinicians state that an increased number of scans are being undertaken but this has not been matched with increased funding for full scan reporting. Health services in Wales have been reformed over the past decade and are being further reconfigured in 2009. The number of Local Health Boards (LHBs) is being reduced from 22 to eight and the ten NHS trusts are being dissolved and amalgamated with the new LHBs as unified health organisations. This will abolish the internal market in the NHS in Wales and it is hoped that this will offer the opportunity to get unambiguous, clear approaches to osteoporosis treatments for primary and secondary care. Clinicians have voiced concern, however, that in the current economic climate they will work in an arena
of service cuts and may not be able to develop new or existing services. Promoting bone health requires a long-term approach and many services have been developed on the understanding that money would be saved in the long term, but savings need to be made ‘up front’. Countering this requires meaningful measurement of outcomes, including audit, linked with the message that care for fragility fracture patients is expensive. The National Hip Fracture Database (NHFD) aims to promote best practice in the care and secondary prevention of hip fracture through benchmarking. Of the 13 hospitals in Wales who admit patients with a fractured neck of femur, only seven have signed up to the NHFD and four actively participate. Data from the NHFD puts users in a position to demonstrate their performance to take advantage of the best practice tariff for fractured neck of femur that is proposed for England but not available in Wales. However, those using the NHFD in Wales find it a useful tool when they argue for resources, having identified what needs improving, although some clinicians admit that grasping the politics of securing funding is difficult and time-consuming.

**National guidance**

The National Institute for Health and Clinical Excellence (NICE) was established in 2005 as an England-only Special Health Authority. The WAG partially funds NICE and an agreement is in place covering technology appraisals, interventional procedure guidance and clinical guidelines, which all continue to apply in Wales. The NICE guidance for primary and secondary prevention of osteoporotic fractures is being debated by the Welsh Osteoporosis Advisory Group (WOAG) who are also considering the application of the FRAX® tool and National Osteoporosis Guideline Group (NOGG) guideline in Wales. WOAG members are health professionals from across Wales with an interest in osteoporosis. The group launched the Osteoporosis and Fracture Prevention Strategy for Wales with the National Osteoporosis Society in 2003. This strategy was developed to assist LHBs improve osteoporosis management and it advocated establishing local interest groups to facilitate multidisciplinary implementation of the framework. This included selective case finding for three high-risk groups: patients with a previous fragility fracture, patients on oral steroids and frail elderly patients. Six years later, only two funded and fully operational Fracture Liaison Services (FLSs) exist in Wales, covering inpatients and outpatients. These services were established as a result of the perseverance of a local champion, the involvement of public health networks, the support of the National Osteoporosis Society and because local LHBs recognised osteoporosis as a priority for funding. The Ceredigion Integrated Osteoporosis Service approach was to not only develop an FLS but also target patients in primary care on oral steroids and the residents of care homes.

In addition to NICE, the All Wales Medicines Strategy Group (AWMSG) provides advice on prescribing and strategic medicines management to the Minister for Health and Social Services in Wales. NHS trusts and LHBs are expected to follow guidance from these bodies and provide the advised treatment within three months of the issue of NICE guidance or the endorsement by the Minister of AWMSG guidance. The AWMSG appraisal process takes about six months and can be timed to endorse the medicine for the NHS Wales as soon as possible after the product is marketed within the UK. This can result in use and funding of new medications ahead of the publication of NICE guidance or in its absence (as was the case with teriparatide). NICE guidance, however, takes precedence over AWMSG guidance if the two differ! If a treatment is not included in NICE and/or AWMSG guidance, funding decisions can be made locally by LHBs (this currently includes ibandronate and zoledronate).

**A strategy for Wales**

The National Osteoporosis Society launched a manifesto for Wales at the NAFW Senedd (parliament) to politicians and policymakers in May 2009. The document, Protecting fragile bones, sets out the key challenges that must be met in Wales to improve osteoporosis
management and reduce fracture risk. These challenges mirror those in the National Osteoporosis Society’s manifestos for England, Scotland and Northern Ireland, namely:

- Management of fragility fracture patients through provision of FLSs
- Clinical guidance for falls, osteoporosis and fractures
- Assessment of clinical performance
- Incentives to influence the management of osteoporosis in primary care
- Improvement in the public understanding of bone health.

The manifesto for Wales highlights that the assessment of osteoporosis and falls risk is included in the National Service Framework (NSF) for Older People in Wales (part of the ten-year Strategy for Older People in Wales). The NSF in Wales sets out a specific standard on falls and bone health in more detail than the 2001 English NSF for Older People, focusing on three areas of activity: falls prevention, care after a fall, and prevention and management of osteoporosis. The section on osteoporosis reflects the three target groups identified in the earlier National Osteoporosis Society/WOAG strategy and also emphasises the need to integrate primary and secondary care. However, an organisational audit of falls and bone health, conducted by the Royal College of Physicians, demonstrated that, although progress has been made, significant gaps remain in service provision in Wales and management of osteoporosis lags behind falls services. Some clinicians believe that this is due to lack of funding to implement the NSF and LHBs concentrating on falls, with money becoming available being allocated to short-term falls projects. The audit also demonstrates that orthogeriatricians, regrettably, remain a rare breed in Wales.

Osteoporosis and fragility fractures are not included in the Quality and Outcomes Framework but in England, Scotland and Northern Ireland ‘directed enhanced services’ partially compensate for this. The osteoporosis manifesto for Wales acknowledges, however, that there is a worrying vacuum in Wales. Some LHBs have a ‘local enhanced service’ such as Swansea LHB that was informed through replicating the osteoporosis part of the QRESEARCH study.

The National Osteoporosis Society provides information to the public through 11 support groups across Wales. Chris Swan, Chair of the Ceredigion group, is mindful of the inequality of services in Wales and states that ‘whilst grateful for our local services we are concerned that other areas do not have access to services, particularly in rural localities’. Patients in rural communities of mid- and north Wales cite problems with access to services because of poor public transport and long distances to travel. The WAG has undertaken a consultation process in 2009 to review rural health planning, including an examination not only of transport issues but also the use of telemedicine. Telemedicine is used in rural communities routinely to support cancer services and may also offer a way forward in osteoporosis management.

**The future**

Current organisational changes in Wales are very complex and will take time to become established. The integration of primary and secondary care must be seen as a welcome approach, in terms of providing seamless care to patients. For effective management of secondary fracture prevention, the current NICE guidance is too unwieldy, with (potentially) multiple decision points...
compared with a single decision to treat (based on ten-year fracture risk) followed by approved therapies used in the most cost-effective manner. A significant challenge to healthcare in Wales is the rurality; providing high-quality, evidence-based healthcare to all patients in Wales regardless of their place of residence requires alternative approaches that are both clinically and cost-effective.

Acknowledgements
Thank you to the health professionals and patients who contributed their views to this article. Image courtesy of Dr Phil Jones, Consultant Physician, Bronglais General Hospital.

References
12. The Clinical Effectiveness and Evaluation unit, Royal College of Physicians. National Audit of the Organisation of Services for Falls and Bone Health in Older People. www.rcplondon.ac.uk/CLINICAL-STANDARDS/CEEU/CURRENT-WORK/FALLS/ Pages/Audit.aspx#round2_audit_2008 (last accessed 30/09/09)

Key points
- The National Osteoporosis Society’s manifesto for Wales defines funding priorities.
- Organisational changes will see Wales moving away from a competitive market basis, which will offer opportunities in the long term to improve services.
- ‘Workable’ clinical guidance and monitoring practice are essential for a systematic approach to osteoporosis.