JOINT DELIVERY?

An updated audit to assess progress in the implementation of the *Musculoskeletal Services Framework* in England

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Chapter 1: executive summary

For too long musculoskeletal conditions, encompassing around 200 different conditions affecting the muscles, joints and skeleton have been under-prioritised in the NHS. Previous research by the Arthritis and Musculoskeletal Alliance (ARMA) has revealed large variation in the delivery of services across England as well as in money spent on services as a result of a lack of prioritisation and understanding of musculoskeletal conditions and their impact across public health, the NHS and social care.

The Government's health and social care reforms, with their focus on improving clinical outcomes, greater integration between health and social care and aims to deliver high quality, personalised care provide opportunities to improve services for people with musculoskeletal conditions.

With the transfer of commissioning responsibilities at a local level from Primary Care Trusts to Clinical Commissioning Groups already underway this new report from ARMA shows that musculoskeletal services continue to suffer from large scale variation in the way they are delivered.

Specifically over half of commissioners said that they did not include musculoskeletal conditions within their definition of long term conditions. The research also reveals a greater than thirteen fold variation in the amount of money being spent by commissioners on patients with musculoskeletal conditions, which cannot be attributed solely to differing local needs. Despite this only one in five commissioners could confirm that they had had a board level discussion about variations in musculoskeletal service provision.

The report finds variable progress in delivering the recommendations of the Department of Health's Musculoskeletal Services Framework (MSF).

There have been specific improvements in relation to the proportion of commissioners providing information to patients, those operating a Clinical Assessment and Treatment Service, and those providing education and training to GPs on rheumatoid arthritis. In other areas, such as integrating their falls service with their local authority and auditing outcomes for people with musculoskeletal conditions, no progress has been made and worryingly it appears that fewer commissioners are adopting the practices outlined in the MSF.

Of concern given the transition underway in health and social care services one in ten PCTs admitted to having no communication with pathfinder commissioning groups in their area and nearly one in four said that they had had no communication with pathfinder commissioning groups on musculoskeletal conditions.

In order to ensure that the new system delivers the improvements that are desperately needed, ARMA has identified thirty recommendations which if implemented would improve services for patients. This includes the need for the Department of Health to publish a national outcomes strategy for musculoskeletal conditions to outline how the new structures and commissioning systems will deliver improvements in care. Given that musculoskeletal conditions are the fourth largest area of programme budget spend in the NHS and outcomes strategies have been published for cancer, mental health and chronic obstructive pulmonary disease and asthma ARMA believes that this strategy should be developed as a matter of urgency.

Chapter 2: variations in the quality of musculoskeletal services

ARMA first undertook an audit of musculoskeletal services in July 2009 to determine how the recommendations from the Department of Health's MSF were being implemented. ARMA's report, *Joint Working?*, found that application of the framework and its associated recommendations varied greatly between local commissioners and called for the appointment of a national clinical director and a national musculoskeletal strategy to be implemented to address this variation.

Two years on from *Joint Working?*, ARMA undertook an updated audit of musculoskeletal services in England to see what progress, if any, has been made and to develop a baseline against which new national and local commissioners of musculoskeletal services can be assessed.

It is intended that the key findings and recommendations of this report will be used by policymakers, commissioners and clinicians in order to drive continuous improvements in the quality of services for people with musculoskeletal conditions.

Key findings

The findings of the updated audit demonstrate that the provision of musculoskeletal services continues to vary considerably across the country.

Variation

- Many PCTs are commissioning musculoskeletal services without first collecting enough information to make an accurate assessment of the needs of their local population going against existing guidance in the MSF. Only 38% have identified all long term conditions patients in their area, 37% said that they did not use programme budgeting data to define their resource allocation for certain conditions and only 43% contain musculoskeletal conditions within their definition of long term conditions

- Services are being delivered in a variable way across the country. Although some of this variation may be accounted for by differences in local need, much of it is a result of accident rather than design. Just 35% of PCTs have mapped resources for people with long term conditions in their area

- There is a greater than thirteen fold variation in the amount of money being spent by commissioners on patients with musculoskeletal conditions, which cannot be attributed solely to differing local needs

- 78% of PCTs said that they had had no discussion at a board level about variations in service provision

Outcomes

- 71% of PCTs have not conducted an audit of outcomes for musculoskeletal patients, and of those that have, the outcomes used are not measured consistently around the country, making it difficult to benchmark and compare local services on the basis of quality

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Integration

- Services for musculoskeletal conditions continue to be fragmented, with 82% of commissioners not integrating their clinical assessment and treatment services (CATS) with local pain management services and 48% of PCTs not integrating their falls services with interventions provided by their local authority. In addition, the staffing levels of CATS vary greatly between different commissioners

Education and training

- 49% of commissioners still do not provide education and training to GPs on musculoskeletal conditions to help improve diagnosis rates and patient outcomes. This calls into question whether the Department of Health has delivered on its commitment to improve GP training, made in response to the Public Accounts Committee report on rheumatoid arthritis

Engagement with voluntary and community groups

- 43% of PCTs do not work with or engage with voluntary and community groups in the delivery of musculoskeletal services and 12% of PCTs do not provide information to musculoskeletal patients to help them self-manage their condition, reducing the ability of patients to live independent lives and potentially increasing the cost burden on the NHS

Work

- 57% of PCTs have not made links with Pathways to Work or similar return to work schemes to assist patients with musculoskeletal conditions in returning to the workplace

Clinical effectiveness

- 40% of PCTs have not identified clinical champions for musculoskeletal conditions, who can help integrate musculoskeletal services across the care pathway

- 95% of PCTs have made no assessment of the capacity and cost of delivering intravenous services for patients in a primary or secondary care setting, despite the growing role of intravenous and subcutaneous injection administered drugs in managing musculoskeletal services

- 91% of PCTs have made no assessment of the referral time for a follow-up appointment for a patient with rheumatoid arthritis, despite the importance of such appointments to monitoring a patient's condition

Application of existing guidance

- 73% of PCTs claim to have not received communication with the Department of Health on the Atlas of Variations report and 67% have not reviewed their musculoskeletal services since the publication of the Atlas of Variations report, even though this report provides useful guidance for addressing variation in the delivery of musculoskeletal services

- 81% of PCTs said that they had had no communication from the Department of Health on the MSF, and 76% said that they had had no communication with their SHA on the framework. This is despite the fact that the MSF remains the most recent national policy document on the effective delivery of musculoskeletal services

Engagement with new commissioning groups

- 13% of PCTs admitted to having no communication with pathfinder commissioning groups in their area and 24% said that they had had no communication with pathfinder commissioning groups on musculoskeletal conditions. This is despite the increasing role for new commissioners in commissioning musculoskeletal services

Although ARMA recognises that some variation will arise within healthcare systems where commissioners and providers respond to the specific needs of their local population, much of the variation uncovered by this audit cannot be explained by demographic differences alone.

Rather, there are concerning inequities in expenditure, potentially caused by inadequate or inaccurate assessments of local needs, and variations in the cost and efficiency of services.

Moreover, key markers of quality – such as the involvement of voluntary or community groups in provision of services – are absent from much of the commissioning process. The majority of PCTs are still failing to collect information on patient outcomes which would enable them to analyse quality and efficiency of the services they commission.

Chapter 3: assessing progress

In comparison with two years ago, our analysis found an improvement in four areas identified as a priority by the MSF:

- A 6% improvement in the proportion of PCTs operating a Clinical Assessment and Treatment Service (CATS)
- A 19% increase in the proportion of PCTs mapping their use of resources for long term conditions
- A 1% increase in the proportion of PCTs providing information to musculoskeletal patients to help them self-care
- A 8% improvement in the proportion of PCTs providing education and training to GPs on rheumatoid arthritis

However in eight areas our updated audit found that implementation of the MSF's recommendations has actually declined:

- A 2% decline in the proportion of PCTs integrating their CATS with their pain management service
- A 21% decline in the proportion of PCTs integrating their falls services with their local authority
- A 2% decline in the proportion of PCTs including musculoskeletal conditions within their definition of long term conditions
- An 11% decline in the proportion of PCTs carrying out audits of outcomes for patients with musculoskeletal conditions
- A 6% decline in the proportion of PCTs working with voluntary and community musculoskeletal organisations
- A 16% decline in the proportion of PCTs identifying musculoskeletal clinical champions
- A 3% decline in the proportion of PCTs assessing the costs and capacity of intravenous services for people with inflammatory arthritis
- A 2% decline in the proportion of PCTs undertaking an assessment of the follow-up referral time for a patient with rheumatoid arthritis

The proportion of PCTs making links with back to work schemes has remained static since *Joint Working?* This is despite the profile given to the issue through the work of Dame Carol Black, and the ongoing debates about how people with long term conditions can be supported in re-entering the labour market, so easing the welfare burden.

It is worth noting that whilst the percentage changes are generally small, the general trend is of an absence of progress since the publication of *Joint Working?*

Chapter 4: recommendations

As a result of the large scale variation identified in *Joint Working?* the musculoskeletal community has been united in its view that a dedicated outcomes strategy is required to support improvements in the quality and efficiency of musculoskeletal services.

This would provide the national direction and impetus to drive up outcomes whilst managing resources more effectively, and reducing the overall burden of disease. Without a programme-level strategy, musculoskeletal services will fall further behind in the face of major NHS change and budgetary constraint.

Health services are not used to prioritising musculoskeletal services and, without the right support through for example the creation of musculoskeletal networks, they are less likely to be able to leverage the NHS reforms in such a way that will benefit patients.

In addition to these overarching recommendations, ARMA makes the following detailed recommendations:

Recommendation 1: new health and wellbeing boards should ensure that Joint Strategic Needs Assessments (JSNAs) are carried out in full, including mapping the musculoskeletal population and the NHS Commissioning Board should monitor their completion

Recommendation 2: new clinical commissioning groups should undertake assessments of the use of resources for people with long term conditions, including musculoskeletal conditions, as part of the JSNA

Recommendation 3: the Department of Health should designate a Public Health Observatory to become the lead supplier of data on musculoskeletal services and develop commissioning information packs to support this data

Recommendation 4: health commissioners should hold a definitive list of long term conditions that includes musculoskeletal conditions

Recommendation 5: new clinical commissioning groups should ensure that adequate training is available to GPs to assist them in diagnosing and treating patients with musculoskeletal conditions, as well as referring to specialist assessment and treatment

Recommendation 6: the Department of Health should work with charity partners to develop a training information portal on musculoskeletal conditions for GPs

Recommendation 7: the NHS Commissioning Board should sponsor musculoskeletal networks in order to support providers and commissioners to deliver improvements in the quality and efficiency of services, and the outcomes and experiences of patients

Recommendation 8: PCTs and clinical commissioning groups should provide information for patients on musculoskeletal conditions to help them self care. This should include public information campaigns and commissioners should work with Public Health England to deliver these campaigns

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Recommendation 9: PCTs and clinical commissioning groups should consult and work with voluntary and community organisations in the delivery of musculoskeletal services

Recommendation 10: PCTs and clinical commissioning groups should identify clinical champions for musculoskeletal diseases to take charge and lead the integration of musculoskeletal services

Recommendation 11: all PCTs and clinical commissioning groups should ensure that patients with musculoskeletal conditions have access to a CATS and that their CATS are appropriately staffed

Recommendation 12: PCTs and clinical commissioning groups should work with local authorities through the introduction of health and wellbeing boards to integrate their falls service with the local authority

Recommendation 13: the national commissioning board should require clinical commissioning groups that fail to satisfy the 18-week referral to treatment standards to produce a plan to improve timely access to treatment and report against this plan

Recommendation 14: PCTs and clinical commissioning groups should carry out assessments of the average waiting time for a follow-up appointment for rheumatoid arthritis to ensure patients are getting access to the follow-up care they need to help them manage their condition

Recommendation 15: building on the commitment for NICE to develop quality standards for musculoskeletal conditions, NICE should prioritise these standards based on the relative absence of and adherence to existing guidance

Recommendation 16: PCTs and clinical commissioning groups should undertake an assessment of the capacity and cost of intravenous services as part of their commissioning plans to ensure there is sufficient capacity for patients to benefit from new treatments

Recommendation 17: as part of their assessment of their CATS service PCTs and clinical commissioning groups should integrate the service with their local pain management service

Recommendation 18: PCTs and clinical commissioning groups should develop partnerships with organisations and schemes to support musculoskeletal patients to stay in or return to work

Recommendation 19: Health and wellbeing boards should ensure that local health and local authority commissioners of public health, health and social care services develop partnerships with back to work schemes for musculoskeletal patients

Recommendation 20: the Department of Health should develop a set of standard outcome indicators for musculoskeletal conditions and include these in the next NHS Outcomes Framework

Recommendation 21: PCTs and clinical commissioning groups should undertake an assessment of their programme budget spend in relation to musculoskeletal conditions and the NHS Commissioning Board should benchmark this spend against other commissioners to ensure adequate resource is being spent on musculoskeletal conditions in their area

Recommendation 22: the Department of Health should ensure that all PCTs and clinical commissioning groups are aware of existing guidelines on musculoskeletal conditions including the MSF and Atlas of Variations report

Recommendation 23: PCT and clinical commissioning group boards should collect data on clinical outcomes as well as PROMs and PREMs and use this to inform the way that services are commissioned

Recommendation 24: the Department of Health should engage with new clinical commissioning groups prioritising musculoskeletal conditions to identify areas of good practice commissioning of musculoskeletal services

Recommendation 25: the commissioning outcomes framework should contain measures and metrics to ensure that the quality of care for musculoskeletal conditions improves

Recommendation 26: the NHS commissioning board should develop CQUINs for musculoskeletal conditions to incentivise providers to improve the quality of services

Recommendation 27: the Department of Health should develop a national outcomes strategy for musculoskeletal conditions

Recommendation 28: good practice commissioning guidance should be developed as a priority and be consistent with quality standards developed by NICE

Recommendation 29: health and wellbeing boards, Healthwatch and patient groups should play a facilitating role for public and patient involvement in the commissioning of musculoskeletal services. New health and wellbeing board learning networks should play an important role in this

Recommendation 30: commissioners and providers should ensure that patients can make informed choices about their care, making full use of decision aids, information prescriptions and voluntary sector advice

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Chapter 5: methodology

The purpose of this audit is to provide a balanced assessment of the impact of policies to improve musculoskeletal services and to ascertain whether any progress had been made since the last audit was undertaken in July 2009. In addition ARMA wanted to determine what impact the transition to the new health and social care structures was having on musculoskeletal services around the country.

In order to inform the evaluation, an audit was undertaken using the Freedom of Information Act 2000, encompassing all primary care trusts (PCTs). The questions that were sent as part of the audit are included in the Annex.

Response rate

Every PCT in England was surveyed as part of the audit. 103 out of the 151 PCTs, 68%, replied within the allocated timeframe of twenty working days and their responses have informed the analysis for this report.

This response rate was comparable with the previous audit.[i] We are grateful to those NHS organisations which did respond. It is, however, disappointing that not all NHS organisations did so and others took longer than the twenty working day deadline to respond. We would like to remind all NHS organisations that, as public authorities, they are required by law to respond to Freedom of Information requests in a timely manner.

As NHS organisations are not duty-bound to respond to Freedom of Information requests in a set format, the information we received was not directly comparable. The analysis used in this report is therefore based on ARMA's own interpretation of the evidence received.

In some cases the differences between the audit in 2009 and 2011 are relatively small. If a different set of PCTs had responded to the questions then the findings from the audit may have been different. However as previously noted it is given that the percentage changes are generally small, the general trend from over two thirds of PCTs sampled is of an absence of progress since the publication of *Joint Working?*

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Chapter 6: background

When evaluating the state of musculoskeletal services it is important to consider why these policies were required. This chapter examines the background to initiatives to improve musculoskeletal services.

About ARMA

ARMA is the umbrella body providing a collective voice for the arthritis and musculoskeletal community in the UK. Together, ARMA and its member organisations work to improve quality of life for people in the UK with these conditions. ARMA has 34 member organisations representing a broad range of interests across service user, professional and research groups working in the field of musculoskeletal conditions.

About musculoskeletal conditions

'Musculoskeletal conditions' is a broad term, encompassing around 200 different conditions affecting the muscles, joints and skeleton.[ii] Around 9 million adults, and around 12,000 children, have a musculoskeletal condition in England today.[iii]

Musculoskeletal conditions are a major area of NHS expenditure, comprising a separate 'programme budget' which – in 2009-10 – consumed £4.76 billion (over £13 million a day).[iv] This represents a greater spend than on neurological conditions, diabetes, and infectious diseases, and is an equivalent level of expenditure to that on respiratory conditions.[v] Expenditure on musculoskeletal conditions has risen rapidly in recent years and it is now the fourth highest area of NHS programme budget spend.[vi]

Examples of musculoskeletal conditions include:

- Sprains and strains, which are often self-limiting and can be self-managed appropriately
- Musculoskeletal conditions caused by severe trauma, such as pelvic fracture, spinal cord injury and limb amputation
- Low back pain, which affects around four out of five people at some point in their life
- Repetitive strain injury (RSI) conditions
- Osteoarthritis, which is the most common reason to refer patients for joint replacement surgery
- Osteoporosis which is the main cause of fractures in older people
- Rheumatoid arthritis and other inflammatory arthritis conditions such as ankylosing spondylitis and psoriatic arthritis
- Other autoimmune rheumatic diseases such as systemic lupus erythematosus (SLE), scleroderma and vasculitis
- Chronic pain syndromes such as fibromyalgia and marfan syndrome

The management of musculoskeletal conditions cuts across public health, NHS and social care. Examples of conditions where this is clearly the case include back pain and rheumatoid arthritis.

Musculoskeletal conditions also cost significant amounts in welfare and benefit payments. The overall cost to the UK economy from productivity losses associated with rheumatoid arthritis has been estimated to be £8billion.[vii] NHS expenditure on services for rheumatoid arthritis totaled less than £700 million – with expenditure on social care adding to the overall expenditure of managing the condition. The research noted that:

"*Rheumatoid arthritis impacts heavily on people of working age (it is most common after 40), and is a major cause of sickness absence and – ultimately – worklessness. An employed person with rheumatoid arthritis has an average of 40 days' sick leave a year (compared to 6.5 days for the average person), whilst an NRAS report from 2007 found that, of the 45% of people with rheumatoid arthritis not in work, 28.4% had given up work within one year of diagnosis*."[viii]

The burden of musculoskeletal disease

Despite its significant impact, musculoskeletal services have never been a priority for NHS improvement and there are a range of indicators which could lead to a rise in the prevalence and cost of treating musculoskeletal conditions. These include:

- An ageing population
- The challenges of changing lifestyles
- Heightened worklessness

This rising burden of musculoskeletal conditions necessitates greater focus on improvement of services. The reform agenda presents an opportunity to streamline services and deliver service re-design that is more cost-effective, while also improving the outcomes and experiences of patients.

Significant scope for improvement in outcomes for musculoskeletal disease could be advanced through the provision of additional support for commissioners. For example, many musculoskeletal conditions are highly amenable to improvement, as measured by patient-reported outcome measures (PROMs)[ix], and earlier diagnosis and intervention can reduce the long term health damage associated with inflammatory musculoskeletal conditions.[x] [xi] [xii] For example patients diagnosed with rheumatoid arthritis and started on optimal treatment within twelve weeks stand a much better chance of remission. Furthermore, improving the quality of treatment and care offered to people with musculoskeletal conditions can deliver wider societal benefits: musculoskeletal conditions are a common cause of workplace absence, for example back pain is the number one cause of long-term absence amongst manual workers.[xiii]

The Musculoskeletal Services Framework

Given the huge cost to society and to the NHS of musculoskeletal conditions, the Department of Health published its musculoskeletal services framework (MSF), *A joint responsibility: doing things differently*, in July 2006. Its development was informed by broad engagement with a significant number of voluntary organisations representing patients, NHS staff (including GPs, consultants, nurses, allied health professionals, commissioners), the independent sector and many professional groups.[xiv]

However the implementation of the vision set out in the MSF has been compromised by three inherent limitations:

- It did not set formal ‘standards’ for NHS service delivery, which the NHS was required to meet, like the ‘National Service Frameworks’ which came before it
- It did not set aside any formal funding to develop and improve capacity in musculoskeletal services, with budgets to implement the MSF dependent on what local NHS organisations could find from their already strained resources
- Its implementation was not led by a ‘National Clinical Director’, unlike many of the other areas of NHS expenditure, such as cancer, diabetes, mental health, neurological conditions, heart disease and stroke, kidney disease, and children and maternity services.[xv] Similarly, the commissioning of care for musculoskeletal conditions is not co-ordinated by formal clinical ‘networks’, such as the cancer networks which co-ordinate the provision of cancer care

An audit of the MSF by ARMA in 2009 found large scale variations in the way that the recommendations of the MSF were and in many cases were not being implemented.[xvi] The key findings from the first audit were:

1. There was a thirteen fold variation in the amount that different PCTs were spending on musculoskeletal patients
2. Less than one in five PCTs had mapped their current resources and their use by people with musculoskeletal conditions
3. There was likely to be a large hidden problem associated with musculoskeletal conditions. Many PCTs could not confirm that they had identified all musculoskeletal patients in their area
4. There was a lack of awareness amongst GPs of musculoskeletal conditions – partly as a result of a lack of training – only 43% of PCTs confirmed that they provided training to GPs on rheumatoid arthritis
5. There was a lack of engagement between health commissioners and the voluntary sector in the delivery of care for musculoskeletal conditions with 40% of PCTs not working with voluntary and community organisations
6. More than one in five (21%) PCTs were not operating a Clinical Assessment and Treatment Service (CATS) for musculoskeletal conditions, despite this being described as the ‘keystone’ of the Government’s policy in this area. There was also a huge degree of confusion within the NHS over the best location, purpose and staffing arrangements of CATS
7. Waiting times for musculoskeletal conditions continued to be an issue with almost three in every 20 patients (13.4%) requiring hospital admission for orthopaedic care waiting longer than 18 weeks for treatment

8. Over half (57%) of PCTs had not made links with their local Pathways to Work scheme

9. That a review of the provision of NHS and social care rehabilitation services initiated by the Department of Health in 2006 had yet to be completed

10. 60% of PCTs had not audited the outcomes of patients with musculoskeletal conditions. Of those that had, a variety of outcome indicators were used. The lack of nationally validated outcome measures is cited by a number of PCTs as a reason for not doing so

The report recommended the appointment of a National Clinical Director for musculoskeletal services to lead the development of a new musculoskeletal services strategy.[xvii]

National musculoskeletal policy since the publication of *Joint Working?*

Whilst to date no clinical director has been appointed and no strategy has been developed, there have been a number of significant policy developments in relation to musculoskeletal conditions since the audit.

- The National Audit Office[xviii] and Public Accounts Committee published reports into services for people with rheumatoid arthritis[xix]

- Commitments were made to refer the case for a national clinical director and national musculoskeletal strategy to the National Quality Board[xx]

- NICE has included a number of musculoskeletal conditions within the planned library of topics for the development of NICE quality standards[xxi]

- The Department of Health has announced a new national clinical audit for rheumatoid arthritis[xxii]

National Audit Office: services for people with rheumatoid arthritis

Soon after the publication of the audit, the National Audit Office released its report on services for people with rheumatoid arthritis.[xxiii]

The report highlighted a number of issues in relation to the treatment and care of patients with rheumatoid arthritis including:

- **Limited patient awareness of the condition** – many patients who have rheumatoid arthritis often delay seeking medical help from their GP as a result of a lack of awareness about the condition. The report found a lack of support and information to help patients better manage their condition. It found that *"between half and three quarters of people with rheumatoid arthritis delay seeking medical help from their GP for three months or more following the onset of symptoms, and around a fifth delay for a year or more"*

- **Delayed diagnosis by clinicians** – many GPs were not diagnosing patients with rheumatoid arthritis quickly adding that *"people with rheumatoid arthritis visit a GP on average four times before being referred to a specialist for diagnosis, and 18 per cent of patients visit more than eight times"*

- **Lack of co-ordinated care** – patients with rheumatoid arthritis suffered from a lack of coordinated multidisciplinary services resulting in them not receiving access to holistic care

- **Access to treatments** –14% of trusts were not able to prescribe new biologic treatments to all patients in accordance with National Institute for Health and Clinical Excellence (NICE) technology appraisal guidance

- **Back to work support** – the report found that the NHS did not consistently provide support or information to people with rheumatoid arthritis to help them remain in or return to work

- **Referral time for treatment** – the 18 week referral to treatment standard had led to a significant increase in the percentage of rheumatology patients being seen and treated by a specialist within 18 weeks of referral

- **Commissioning incentives and levers** – the report found that only 11% of PCTs had compared the number of people in their area with rheumatoid arthritis against the expected number of cases, resulting in a majority not knowing if they are effectively identifying people with the disease, or commissioning sufficient capacity to treat them

The report noted that:

"*Productivity gains could be achieved and patient quality of life improved through better integration and coordination of services, leading to quicker diagnosis and earlier treatment, but in the short-term costs to the NHS would increase. Currently, 10% of people with the disease are treated within three months of symptom onset. Our economic modelling suggests increasing this to 20% could initially increase costs to the NHS by £11 million over five years due to higher expenditure on drugs and the associated costs of monitoring people with the disease (after around nine years, earlier treatment could become cost neutral to the NHS). This increase in earlier treatment could, however, result in productivity gains of £31 million for the economy due to reduced sick leave and lost employment. On average, this could also increase quality of life by 4% over the first five years, as measured by quality adjusted life years (QALY) gained.*"[xxiv]

In February 2010 the Public Accounts Committee produced its own report entitled *Services for people with rheumatoid arthritis* which made a series of recommendations including the need for:

- Early diagnosis to improve outcomes for patients

- Greater awareness of and better training for GPs about the condition

- Improvements in the commissioning of care

- Better integration of care across the care pathway

- Improvements in access to specialist care

- Variations in the delivery of care and access to treatments to be addressed

- A greater focus on the work agenda[xxv]

In response, the Government did commit to work with a group of charities to produce materials aimed at raising awareness of inflammatory arthritis conditions and to seek a commitment from the Royal College of General Practitioners (RCGP) that rheumatoid arthritis is adequately covered in the GP training curriculum. However, a number of the other recommendations were rejected and the Government has so far argued that further specific action to improve wider musculoskeletal services is not required.

The voluntary sector has decided to build on the recommendations of the report, for example by launching the S Factor public awareness campaign.[xxvi]

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Chapter 7: examining progress

The updated audit has enabled us to examine whether any progress had been made in implementing the recommendations of the MSF.

The following table shows the areas where the number of PCTs implementing the MSF's recommendations has improved, remained static or indeed reduced.

Table 1: Summary of progress made in implementing the Musculoskeletal Services Framework since *Joint Working?*

Improvement since *Joint Working?*	No change since *Joint Working?*	Decrease since *Joint Working?*
Operating a CATS	Developing links with Pathways to Work	Integrating their CATS with pain management service
Mapping current resources for people with long term conditions		Integrating their falls services with local authority
Providing information to musculoskeletal conditions on self-care		Including musculoskeletal conditions within their definition of long term conditions
Providing education to GPs on rheumatoid arthritis		Carrying out an audit of outcomes for patients with musculoskeletal conditions
		Working with voluntary and community organisations
		Identifying musculoskeletal clinical champions
		Assessing the costs and capacity of intravenous services for people with inflammatory arthritis
		Undertaking an assessment of the follow-up referral time for a patient with rheumatoid arthritis

Of the 13 directly comparable metrics obtained from *Joint Working?*, four (31%) have improved since the original audit. A greater proportion of PCTs are operating a CATS, have mapped the use of their resources in relation to patients with long term conditions, provide information to patients to help them self-care and provide education to GPs about rheumatoid arthritis.

There has been no progress on the proportion of PCTs who have made links with the pathways to work programme (now defunct) or other back to work initiatives and schemes.

In eight areas (62%) there has been a reduction in the proportion of PCTs implementing recommendations advocated in the MSF. This is of great concern and perhaps reflects the lack of communication and guidance PCTs have received on the MSF. Only 19% of PCTs said that they had received communication on the MSF from the Department of Health and only 24% said that they had received communication from their SHA on the framework.

In addition, *Joint Delivery?* uncovers continued variation in the following areas:

- Spending on musculoskeletal conditions between commissioners
- Staffing of CATS
- Referral processes for people with musculoskeletal conditions
- Whether PCTs held a central list of long term conditions
- The types of conditions contained in PCT long term condition lists
- The outcomes indicators used by PCTs to audit outcomes for patients with musculoskeletal conditions

The following chapter seeks to analyse the improvements and retrenchments above in greater detail.

Conducting needs assessments

Joint Working? found that many PCTs were commissioning musculoskeletal services without first collecting enough information to make an accurate assessment of the needs of their local population.[xxvii]

This was in contravention of The Local Government and Public Involvement in Health Act 2007 which places a duty on both PCTs and local authorities to work together to *"identify the current and future health and wellbeing needs of a local population"* through a 'Joint Strategic Needs Assessment (JSNA)', and to design the correct provision of services through a 'Local Area Agreement'.[xxviii]
It also went against guidance from the MSF which outlined how a needs assessment for musculoskeletal services should take place:[xxix]

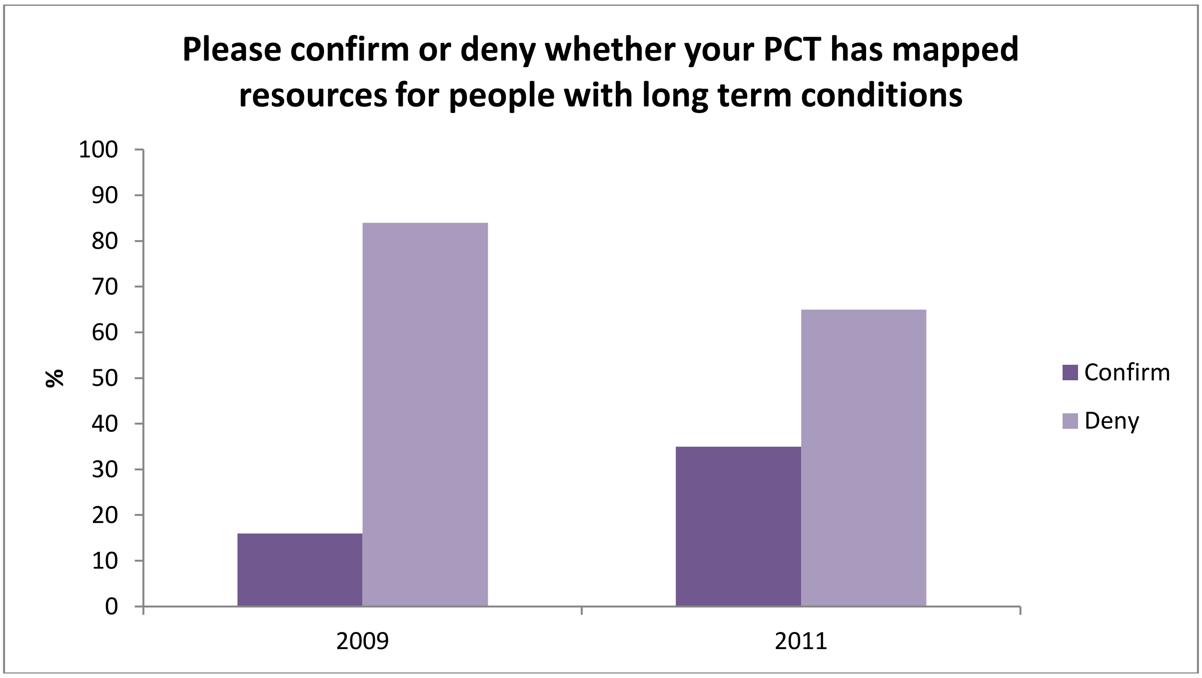
- A mapping exercise to understand the current supply of musculoskeletal services, and how services need to be delivered to meet the priorities of patients

- An estimate of the number of patients living with musculoskeletal conditions in a PCT's health community, both now and in the future, to understand how the current and future supply of musculoskeletal services needs to be provided

Joint Working? found that only 16% of PCTs had followed the guidance of the MSF and mapped *"current resources and their use by people with musculoskeletal conditions, including NHS and other services outside hospital; hospital-based elective and emergency services; and use of diagnostic departments; identify gaps and need for investment"*.[xxx]

Responses to *Joint Delivery?* reveal that the number of PCTs who have mapped their current resources for people with long term conditions has risen to 35% – a 19% improvement.

Figure 2: 2009/2011 comparison of PCTs who have mapped current resources for people with long term conditions



Whilst it is encouraging to see an improvement in the number of commissioners mapping the use of resources for people with long term conditions, 35% remains a worryingly low proportion. Many PCTs said that they had not undertaken a formal mapping exercise themselves and were reliant on existing datasets for such information. NHS Wandsworth for example stated that its:

"Register for LTCs includes the resources available to manage those conditions but a formal mapping has not taken place."[xxxi]

Some PCTs are undertaking work to gather updated intelligence on current resources for people with long term conditions, including musculoskeletal conditions in their area. NHS Wolverhampton for example stated that it has:

"Produced LTC Management Proposed Commissioning Strategy 2008-2011; this is currently being reviewed and conditions will be mapped in regards to prevalence, usage and associated outcomes. [The] PCT has utilised NICE costings templates to map RA, OA, COPD, CVD and asthma."[xxxii]

However, perhaps even more concerning is that of those PCTs who said that they had undertaken the mapping, only two identified the JSNA, despite the fact that it is the tool that should be used for this purpose. The National Indicator Set to be used by NHS organisations in undertaking their JSNAs includes a number of indicators which relate to musculoskeletal conditions and services.[xxxiii]

In the new commissioning structures JSNAs will become the responsibility of health and wellbeing boards. These new boards should ensure that JSNAs are carried out in full, and new clinical commissioning groups should ensure that they carry out an assessment of the use of resources for people with long term conditions, including musculoskeletal conditions, as part of this process.

Recommendation 1: new health and wellbeing boards should ensure that JSNAs are carried out in full, including mapping the musculoskeletal population and the NHS Commissioning Board should monitor their completion

Recommendation 2: new clinical commissioning groups should undertake assessments of the use of resources for people with long term conditions, including musculoskeletal conditions, as part of the JSNA

Estimating the number of people living with long term conditions

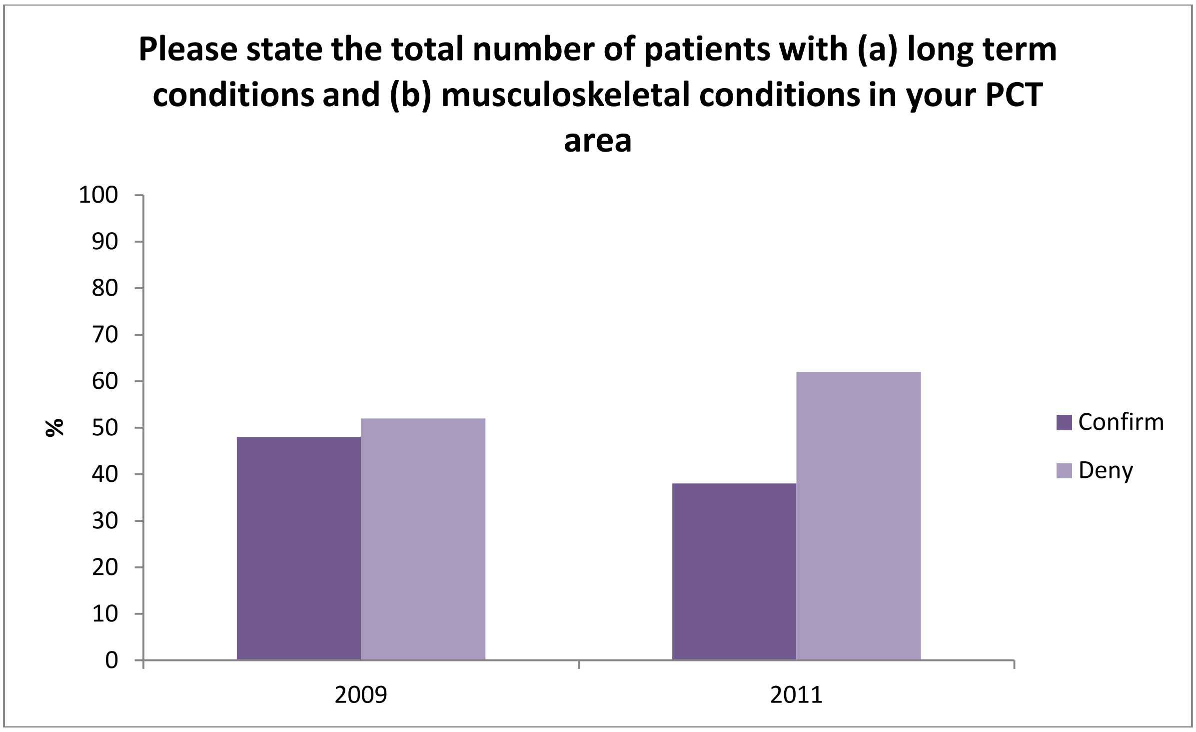
Joint Working? uncovered widespread confusion amongst PCTs over how to calculate and assess the number of people living with long term conditions in their area. Only 48% of those who responded claimed that they had identified all long term conditions patients in their health community.

The MSF states that:

"...the current health status and needs of those with musculoskeletal conditions, including children, should be assessed as part of a population needs assessment using current information sources on people with musculoskeletal conditions in order to understand the incidence and prevalence of musculoskeletal disorders and health and healthcare inequalities."[xxxiv]

Joint Delivery? reveals that no progress has been made in this area, with only 38% of PCTs which responded confirming that they are able to identify the number of long term conditions patients in their area.

Figure 3: 2009/2011 comparison of the proportion of PCTs who have calculated the number of people with long term conditions in their area



The decline in the number of PCTs able to confirm that they have identified the number of people with long term conditions in their area is deeply concerning. Given increasing prevalence rates and the need for commissioners to undertake deep efficiency savings, there is a concern that service efficiencies may be hampered by this lack of information.

Many PCTs who denied that they held this information said that it was not a realistic requirement. For example, NHS Swindon, stated that *"this information is not specifically identifiable and therefore the information is not held"*[xxxv] and NHS County Durham said that it did not have access to this information.[xxxvi]

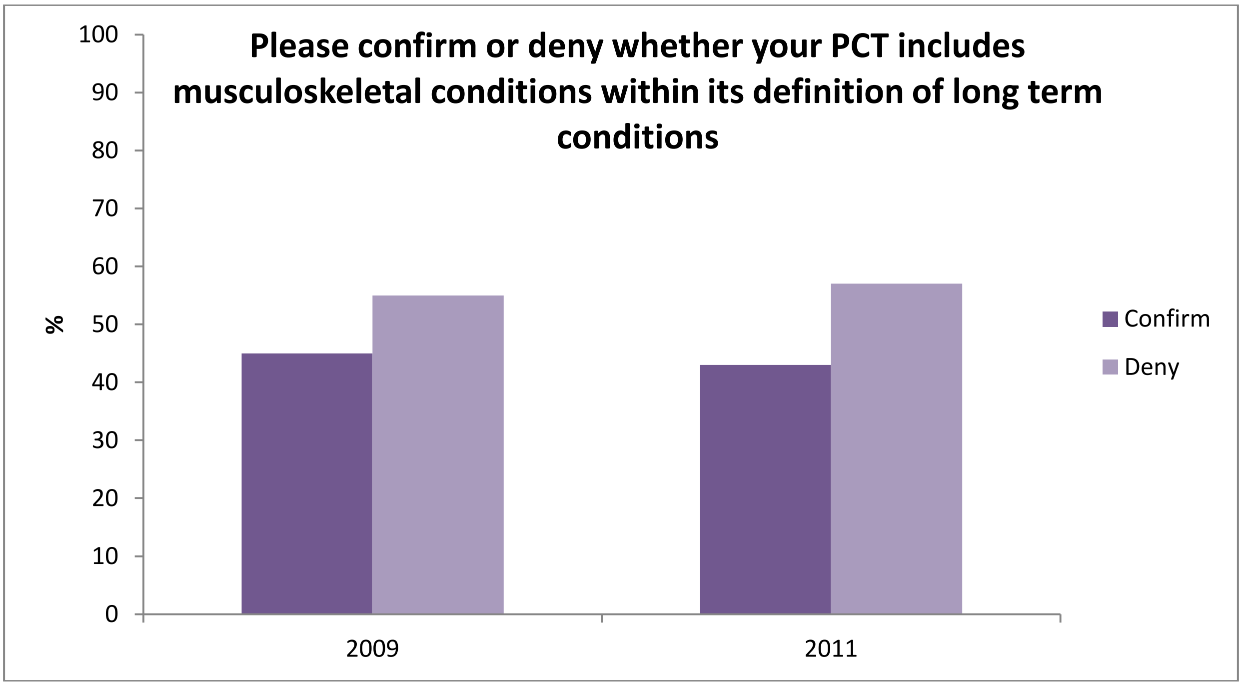
Of those PCTs who had identified the number of people with long term conditions, the numbers varied in their scale and there are also question marks over their degree of accuracy based on variable levels of transparency. Some PCTs such as NHS Wolverhampton provided detailed figures of the number of patients with particular conditions,[xxxvii] whilst others, such as NHS East Sussex Downs and Weald, and NHS Surrey, provided a single figure.[xxxviii] [xxxix] Other PCTs provided an estimated figure, with NHS Wiltshire saying that one third of the population had a long term condition,[xl] and NHS Richmond and Twickenham said that its number was slightly lower than "the average" without noting what its basis was for such a comment and what the average it was referring to was.[xli]

People with musculoskeletal conditions experience a wide range of symptoms - the same condition can affect individuals differently, and they require a range of high quality support and treatment – acute, elective and ongoing. Commissioners must therefore take a sophisticated view of the range of musculoskeletal needs within their local populations. To do this they need high quality, accurate data as the basis for planning and delivering a service that addresses the specific needs of their population, and to identify areas for improvement through benchmarking.

A number of PCTs said that they obtained data on the number of people with long term conditions from the Quality and Outcomes Framework (QOF). Indeed this was a finding of *Joint Working?* and it remains a concern that PCTs continue to rely on the QOF to carry out an assessment of the number of people with long term conditions in their area. Whilst the QOF data will provide a snapshot of patient numbers with particular long term conditions, it is not comprehensive as it only relates to those conditions within the framework. Indeed as many musculoskeletal conditions have never been part of the QOF, any estimation of the number of people with long term conditions taken from this dataset will completely omit the musculoskeletal patient population.

There is a strong case for asking a Public Health Observatory to become the lead supplier of information on musculoskeletal services and to develop commissioning information packs. Alternatively an information network could be created to ensure access to high quality information. *Joint Working?* found only just over half (55%) of PCTs contained musculoskeletal conditions within their definition of long term conditions. *Joint Delivery?* finds that this number has fallen by 13% to only 43%:[xlii]

Figure 4: 2009/2011 comparison of proportion of PCTs including musculoskeletal conditions within their definition of long term conditions



This reduction is deeply concerning. The response of NHS Bolton was indicative of those who did not include musculoskeletal conditions within their definition of long term conditions as the "*PCT does not structure or deliver services under this descriptor.*"[xliii] NHS Calderdale similarly said that it did not define long term conditions *"by these categories."*[xliv] The inability to cross reference their existing list of long term conditions with musculoskeletal conditions suggests a possible ignorance from commissioners regarding which conditions are musculoskeletal conditions. Some commissioners, such as NHS Oldham, merely stated that they used the Department of Health's definition of long term conditions, without elaborating as to whether as a result they had included musculoskeletal conditions within their long term condition definition.

38 PCTs said that they did include musculoskeletal conditions within their definition of long term conditions, though the types and nature of the conditions included within the definition varied. Some PCTs, such as NHS Heart of Birmingham said that they included musculoskeletal conditions broadly in their definition,[xlv] whilst others such as NHS Derbyshire County included specific conditions, such as rheumatoid arthritis and osteoarthritis.[xlvi]

Musculoskeletal conditions are the fourth highest area of programme budget spend in the NHS after cancer, mental health and respiratory conditions and affect an estimated 9.6 million people in England. [xlvii] However, the above findings demonstrate that knowledge of the conditions and their nature as a long term condition remains mixed among commissioners. It is therefore imperative that commissioners not only hold a list of long term conditions but that this includes musculoskeletal conditions to ensure that service capacity is sufficient and able to meet the needs of the local population.

Recommendation 3: the Department of Health should designate a Public Health Observatory to become the lead supplier of data on musculoskeletal services and develop commissioning information packs to support this data

Recommendation 4: health commissioners should hold a definitive list of long terms conditions that includes musculoskeletal conditions

Delivering musculoskeletal services

Patients identified two priorities for musculoskeletal services at the time of the development of the MSF:

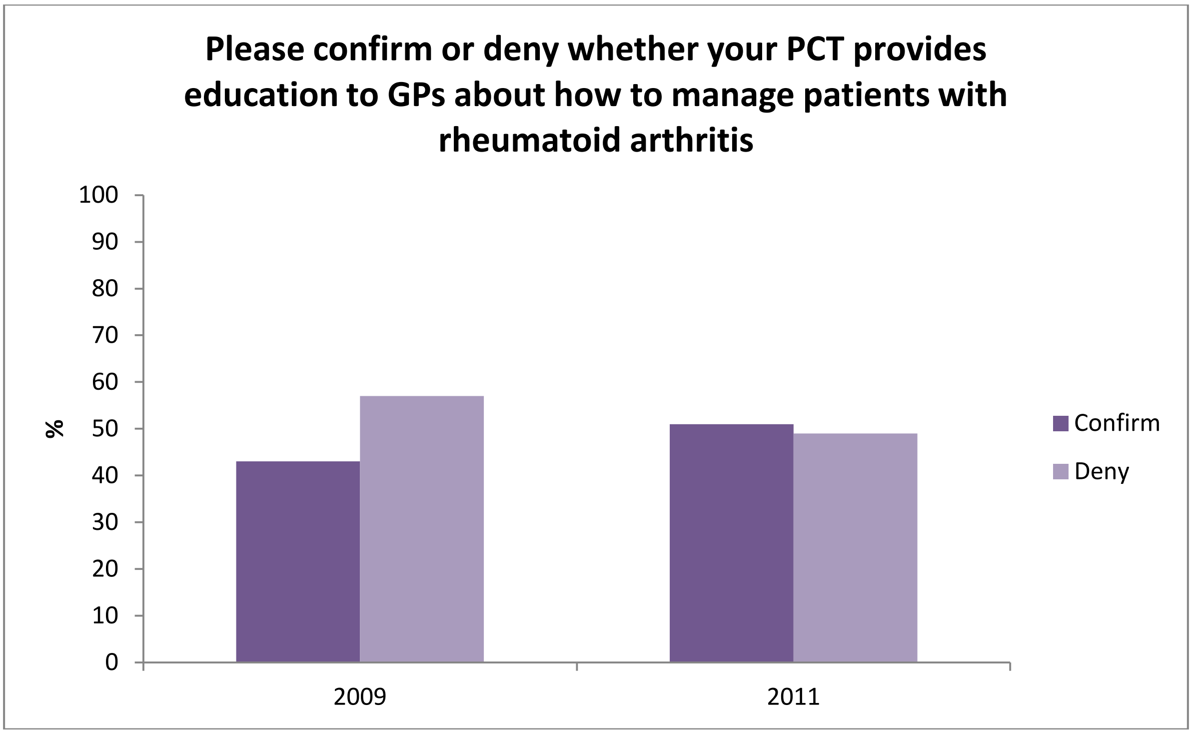
- Speedy and clear access to services
- Good pain control

Early diagnosis and intervention are critical in addressing both of the above, yet patients continue to experience delays in diagnosis and effective intervention as demonstrated in the Public Accounts Committee and National Audit Office reports into rheumatoid arthritis.

Joint Working? noted the importance of GPs in diagnosing patients earlier, though noted that a lack of awareness and incentives were both hindering this process. The report found that only 43% of PCTs provided education for GPs about how to manage patients with rheumatoid arthritis, a condition that affects 550,000 in the UK.[xlviii]

Responses to *Joint Delivery?* find an improvement of 8% in the number of PCTs providing information to GPs on rheumatoid arthritis:

Figure 5: 2009/2011 comparison of the proportion of PCTs providing education to GPs about rheumatoid arthritis



It is encouraging that the number of PCTs providing education to GPs on rheumatoid arthritis has increased, though there is still a great deal of work to be done to ensure that all GPs get access to such education and training.

Of those that did provide education, the type and level of training varied, though there were some very positive examples. NHS Sheffield said that it had run two education sessions – Protected Learning Initiative events – primarily aimed at GPs, practice nurses and other GP staff such as counsellors[xlix], while NHS Sefton similarly said it had run an afternoon workshop on musculoskeletal conditions.[l] NHS Tameside and Glossop ran a TARGET session on RA for the Tameside and Glossop GPs in March 2011; the session was run by a Consultant Rheumatologist and 60 GPs attended.[li]

However, not all PCTs had provided GPs with relevant education and support in this area. NHS West Hertfordshire said that it did not "provide this type of condition-specific training for GPs" and referred us to member organisations the British Medical Association and the Royal College of General Practitioners.[lii] NHS West Sussex said that GPs selected topics for education and training based on high referral demands and had therefore "not chosen" rheumatology as a topic.[liii] NHS Eastern and Coastal Kent said that its training for GPs was in the "development stages",[liv] whilst others such as NHS East Lancashire PCT said that they did not hold this information and told us to contact local providers instead.[lv]

Two years on from the Public Accounts Committee report which criticised the levels of training given to GPs on rheumatoid arthritis it is worrying that many commissioners continue not to provide education and training to GPs to help improve diagnosis rates and patient outcomes. This calls into question whether the Department of Health has delivered on its commitment to improve GP training, made in response to the Public Accounts Committee report on rheumatoid arthritis.

Beyond rheumatoid arthritis, education and training on musculoskeletal conditions more broadly for GPs is important. If GPs fail to diagnose and subsequently refer patients for these conditions, there can be significant consequences for patient outcomes and quality of life.

The findings of our updated audit pose real questions for clinically led commissioning. GPs, who will have a prime role in the commissioning of services for musculoskeletal services through clinical commissioning groups, may have not be the most effective commissioners of musculoskeletal services based on the levels of education they have received on musculoskeletal conditions. However at the same time it may well be the case that by having to take a greater role in the commissioning of services, GPs may become more informed about musculoskeletal conditions and their impact, leading to improvements in diagnosis and earlier interventions.

It will be important to develop the role of clinical networks in supporting commissioners. Clinical networks should be funded by the NHS Commissioning Board so as to ensure that consistent support is available to commissioners and providers in improving the quality and efficiency of musculoskeletal services. Secondly, the way information, education and training on musculoskeletal conditions are communicated by new clinical commissioning groups to GPs potentially raises concerns given the gap in knowledge of GPs on musculoskeletal conditions. Further and more broadly, whether clinical commissioning groups headed by GPs will be best placed to provide information to GPs on conditions and diseases is very much open to debate.

Recommendation 5: new clinical commissioning groups should ensure that adequate training is available to GPs to assist them in diagnosing and treating patients with musculoskeletal conditions, as well as referring to specialist assessment and treatment

Recommendation 6: the Department of Health should work with charity partners to develop a training information portal on musculoskeletal conditions for GPs

Recommendation 7: the NHS Board should sponsor musculoskeletal networks in order to support providers and commissioners to deliver improvements in the quality and efficiency of services, and the outcomes and experiences of patients

Supporting self care

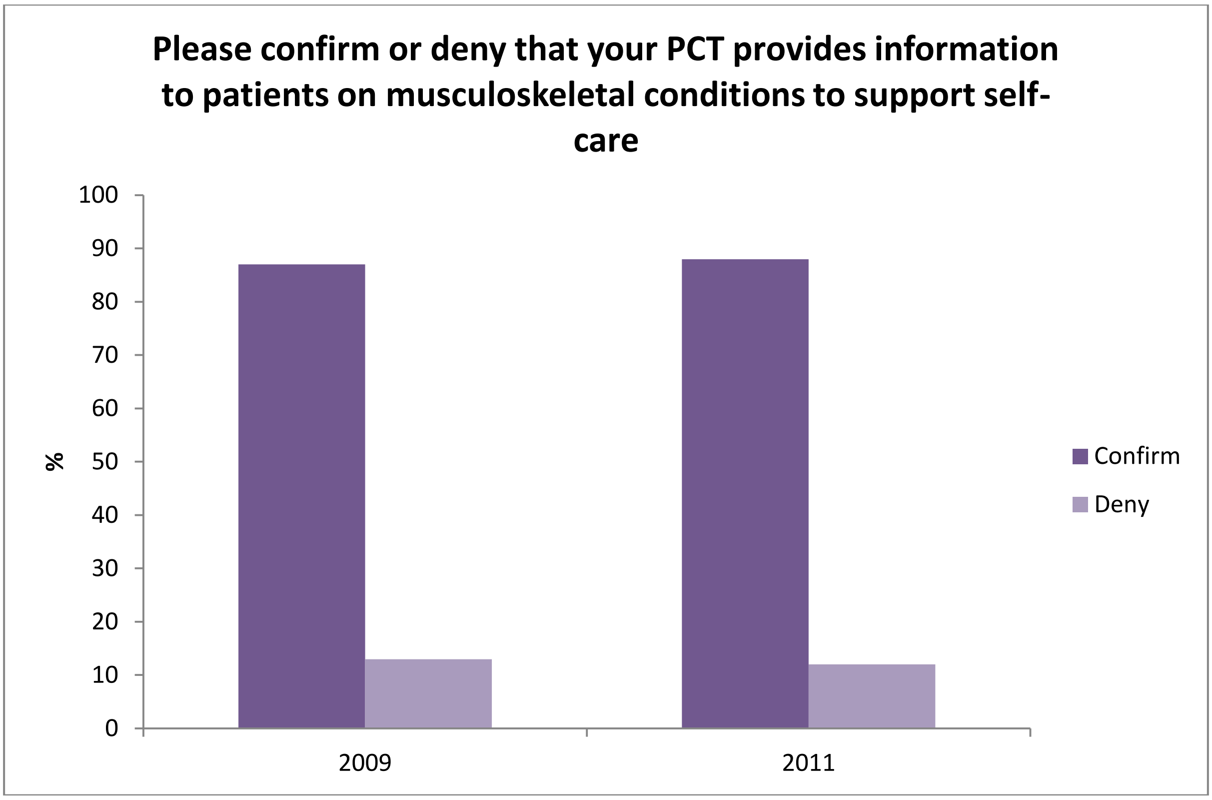
Helping patients to manage their condition is of crucial importance to long term conditions such as musculoskeletal conditions. Without access to accurate and timely information, patients may well take inappropriate measures to self-care which could well lead to their condition worsening.

Joint Working? found that 87% of PCTs provided information to patients on musculoskeletal conditions to support self-care,[lvi] which was a key requirement of the MSF:

> *"To support self-care by providing consistent information on musculoskeletal conditions across their health economy."*[lvii]

Joint Delivery finds that the number of PCTs providing information to patients on musculoskeletal conditions to support self-care is essentially unchanged:

Figure 6: 2009/2011 comparison of the proportion of PCTs providing information to patients on musculoskeletal conditions to support self-care



It is noticeable that more than one in ten of the 84 PCTs who responded to this question said that they did not provide information to support self-care.

The information provided by PCTs varied greatly, with many attaching their leaflets to their freedom of information request response to showcase their offerings.

A growing number of PCTs said that they had developed information portals on their website to assist musculoskeletal patients to self-care. NHS Sheffield for example said that it provides a range of useful information on its website, *"where there is specific reference to the Sheffield Back Pain website which contains a range of information and self help resources".*[lviii]

NHS Essex and NHS Lambeth both said that they signposted patients to NHS Choices for further information.[lix] [lx] This sort of signposting is encouraging and should be more widely adopted.

However it is important that the use of information portals such as NHS Choices is supplementary to commissioner patient information and not a replacement for it, particularly in light of the need for efficiency savings and the upcoming transfer of commissioning responsibilities to clinicians.

As found in *Joint Working?*, a large number of PCTs said they used leaflets from relevant patient groups such as Arthritis Research UK to inform and educate patients.[lxi] NHS Great Yarmouth and Waveney for example said it provided:

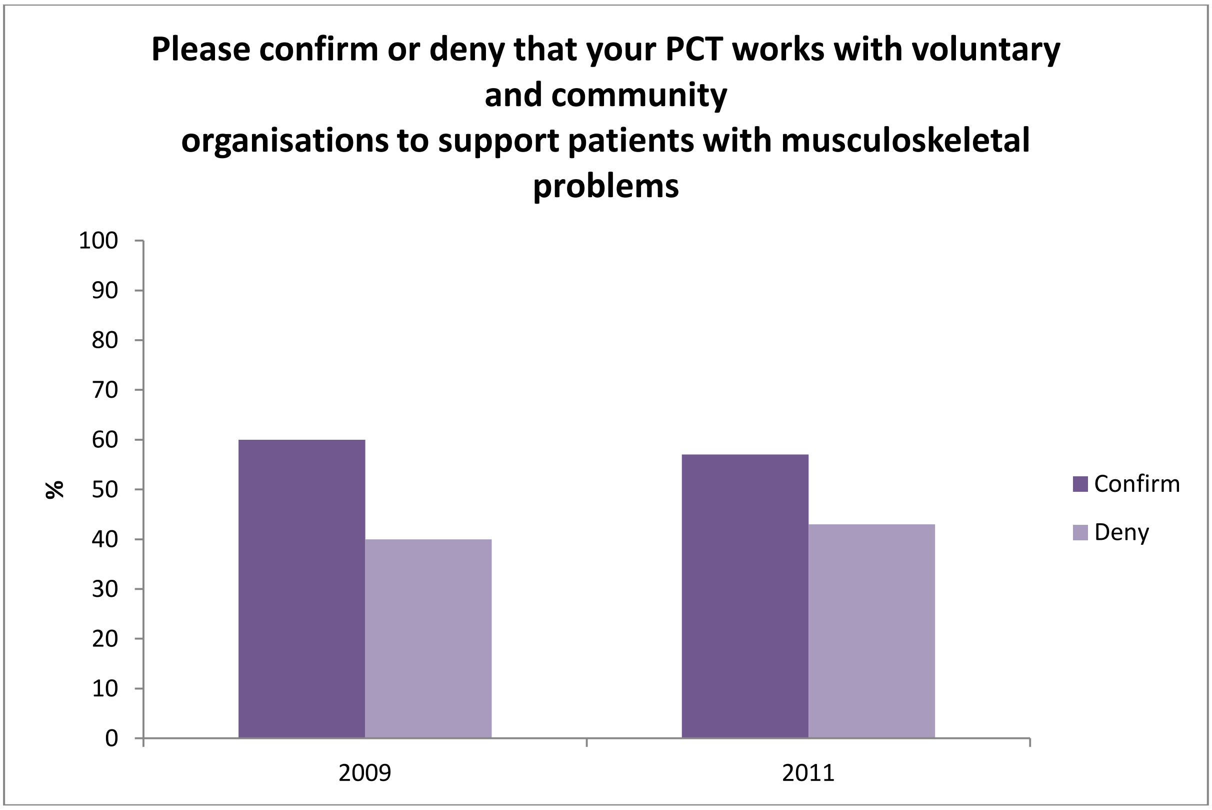
"Copious amounts of ARC leaflets, the back book, the neck book, the whiplash book that are readily available in the public domain and through published sources; personalised info is provided on an individual basis following assessment which can be provided, standard in-house leaflets are also available."[lxii]

This alignment with patient groups to disseminate information is encouraging and reflects the original recommendation of the MSF:

"Voluntary and community support, through self-care networks, education and local health partnerships, can help patients stay as healthy as possible and reduce the risk of developing new problems…health and social care services will want to make sure that as many people as possible benefit from such support."[lxiii]

However it is concerning that the proportion of PCTs working with voluntary and community groups to deliver musculoskeletal services has declined since *Joint Working?* by 3%:

Figure 7: 2009/2011 comparison of the proportion of PCTs who work with voluntary and community organisations to support patients with musculoskeletal problems



Voluntary and community organisations can play an important role in delivering services for patients with musculoskeletal conditions particularly in the community. The support such groups provide benefits patients by helping them to better manage their condition.[lxiv]

Recommendation 8: PCTs and clinical commissioning groups should provide information for patients on musculoskeletal conditions to help them self care. This should include public

information campaigns and commissioners should work with Public Health England to deliver these campaigns

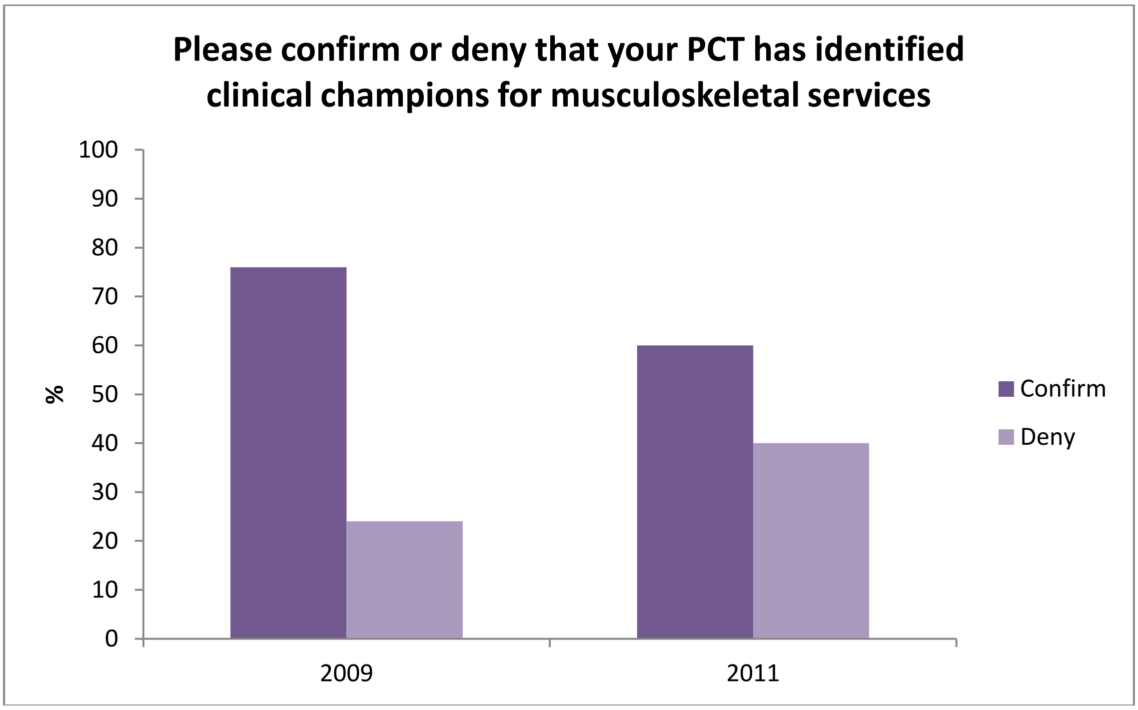
Recommendation 9: PCTs and clinical commissioning groups should consult and work with voluntary and community organisations in the delivery of musculoskeletal services

Collaborative delivery

Whilst a wide number of individuals and groups are involved in the delivery of musculoskeletal care, it is important that such care is wherever possible integrated. Despite the need for integrated care many musculoskeletal patients continue to receive care that is fragmented across different areas of the care pathway.

One of the ways to improve integration identified in the MSF was for commissioners to identify clinical champions in primary and secondary care in their area to take charge of and lead better integration.[lxv] *Joint Working?* found that 76% of PCTs surveyed had identified clinical champions in their area for musculoskeletal services, though added that such a figure was likely to be inflated by commissioners applying the term champion informally.[lxvi] *Joint Delivery?* applied stricter criteria to the definition of a clinical champion and there was a reduction in the proportion of PCTs achieving the criteria:

Figure 8: 2009/2011 comparison of the proportion of PCTs identifying clinical champions for musculoskeletal services



It is concerning that 40% of PCTs who responded to the request were unable to clearly state whether they have identified clinical champions in primary and secondary care to lead effective service integration for musculoskeletal services.

Efforts to increase clinical leadership in commissioning are to be welcomed but should encompass clinicians from all areas of healthcare, and not just primary care. As part of this process, commissioners should be encouraged to designate a clinical champion for musculoskeletal services and this person should be held accountable for performance in improving the integration of care across clinical disciplines and organisational boundaries.

There is evidence that this process is already leading to joint working between professional groups in the delivery of musculoskeletal services. For example NHS Worcestershire replied saying that there would be a *"GP clinical champion from each three GP commissioning consortia in Worcestershire, together with an orthopaedic consultant from its local acute trust."*[lxvii] NHS West Kent found that it had "*identified GP clinical champions for MSK within each PBC locality*," adding that these were "*being reviewed at the moment due to forming of GP consortia, but MSK is a priority in all areas so clinical champions will be identified*."[lxviii]

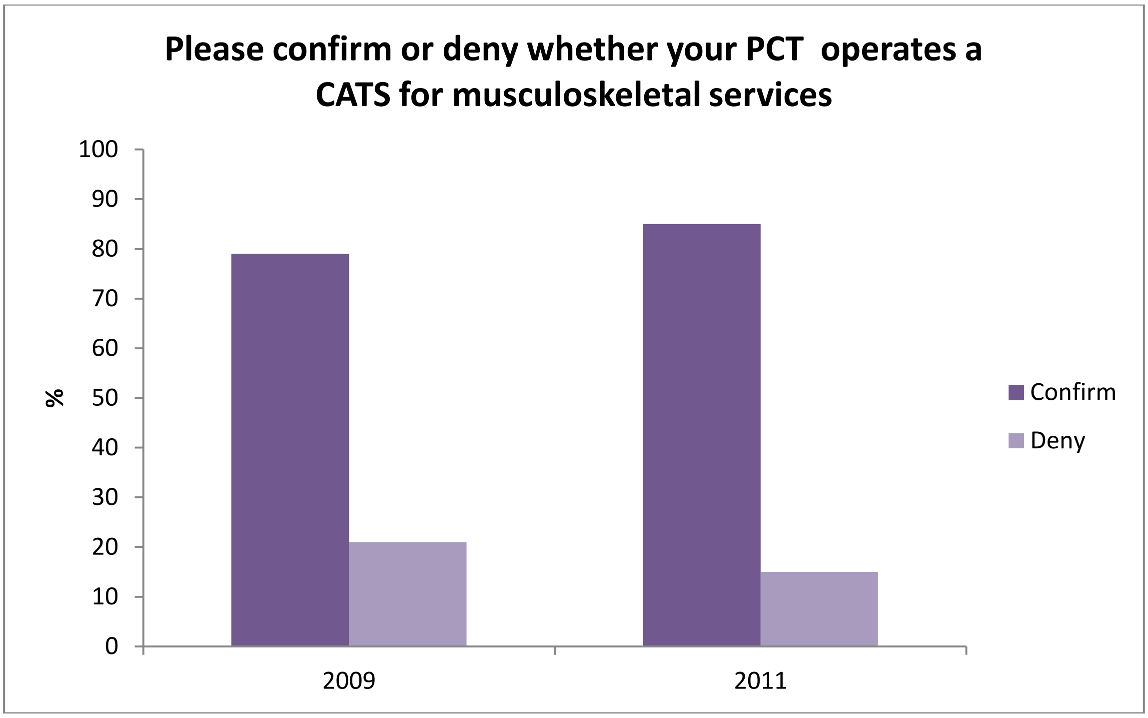
Case study

The Guy's and St Thomas' Hospitals NHS Foundation Trust rheumatology service exemplifies three elements of best practice. The service is structured around the Rheumatoid Arthritis (RA) Centre, a specialist clinic for RA patients which allows clinicians to focus on delivering high quality care. Streamlining patients into this clinic has made resource available such that specialist clinics for other disease types and cohorts have developed. Patient centred care is a primary goal of RA Centre clinicians to ensure that the service they provide is in line with the needs of their patient community. Outcomes from surveys and focus groups have been used to shape the service and to ensure that holistic needs of the patient are addressed in tandem with clinical needs. The rigour applied to monitoring and adherence to evidence based protocols has flowed through to routine clinical practice, such that the recently published NICE guidelines have not needed to prompt a significant change in focus.

The MSF recommended 'clinical assessment and treatment services (CATS)' to ensure that care for musculoskeletal patients was effectively joined up. *Joint Working?* found that over one in five PCTs were not operating such a service and that many had a poor understanding of its role and which professionals should be involved in it.[lxix]

Our updated audit found a slight improvement in the number of PCTs operating a CATS service, with 82 of 96 who responded to this question saying they did operate the service:

Figure 9: 2009/2011 comparison of proportion of PCTs operating a CATS for musculoskeletal services



It is encouraging that the proportion of PCTs operating a CATS service has increased since *Joint Working?* However our updated audit uncovered significant variation in the type of services offered with some PCTs only offering CATS for particular conditions. For example, NHS Swindon only offered CATS for back pain,[lxx] whilst NHS Suffolk only offered the service for those in the east of Suffolk with conditions relating to *"peripheral limbs"*.[lxxi] Whilst it is up to local NHS organisations to determine the nature of their CATS service, based on local need, it is important that access to such services is not limited unnecessarily.

Moreover despite CATS being in existence for over five years, NHS Worcestershire said that its CATS service was only a 'pilot service'.[lxxii] Whilst it is understandable that services may need to be piloted in order to ensure their effectiveness, the piloting of a service that has been in existence for many years, and that has proved effective elsewhere, demonstrates a very slow implementation timetable.

Whilst PCTs were given discretion in the MSF to arrange their CATS services, the framework did outline recommendations in relation to staffing levels:

"CATS bring together skilled health professionals from primary and secondary care – allied health professionals, extended-scope physiotherapists, GPs with special interests, chiropractors, osteopaths and nurse practitioners."[lxxiii]

Joint Working? uncovered large scale variation in the staffing of CATS services.[lxxiv] Responses to *Joint Delivery?* similarly demonstrated three tiers of CATS staffing:

- Advanced – PCTs in this category had staff in their CATS across a range of care and delivery areas. NHS Sandwell for example listed its CATS staff as: "*Physiotherapist, Senior*

Physiotherapist, Physiotherapist Assistants, Senior Podiatrist, Secretaries, Pain Nurse Consultant and Ortho Consultant."[lxxv]

- Basic – PCTs in this band appeared to provide only the most basic level of service through CATS. For example NHS Sefton said that its CATS staff included a *"lead physician, physiotherapist and administrator."*[lxxvi]

- Inadequate – Some PCTs were unable to supply the details of who worked in their CATS. NHS Wolverhampton was typical of such responses saying that *"the PCT does not hold this information,"*[lxxvii] whilst NHS East Sussex Downs and Weald said that it would take longer than the permitted response time for a freedom of information request to find out the information.[lxxviii]

Joint Working? found that only four PCTs claimed to have an occupational therapist in their CATS.[lxxix] In response to the request for information for *Joint Delivery*, only one – NHS Bedfordshire - specifically noted an occupational therapist as being part of their CATS staff.[lxxx] As *Joint Working?* argued occupational therapists have a key role in assisting patients with musculoskeletal conditions in managing their conditions and ensuring that the work they undertake does not exacerbate problems.[lxxxi] The knock-on effects of this are damaging both for the individual involved and their employer.

Recommendation 10: PCTs and Clinical Commissioning Groups should identify clinical champions for musculoskeletal diseases to take charge and lead the integration of musculoskeletal services

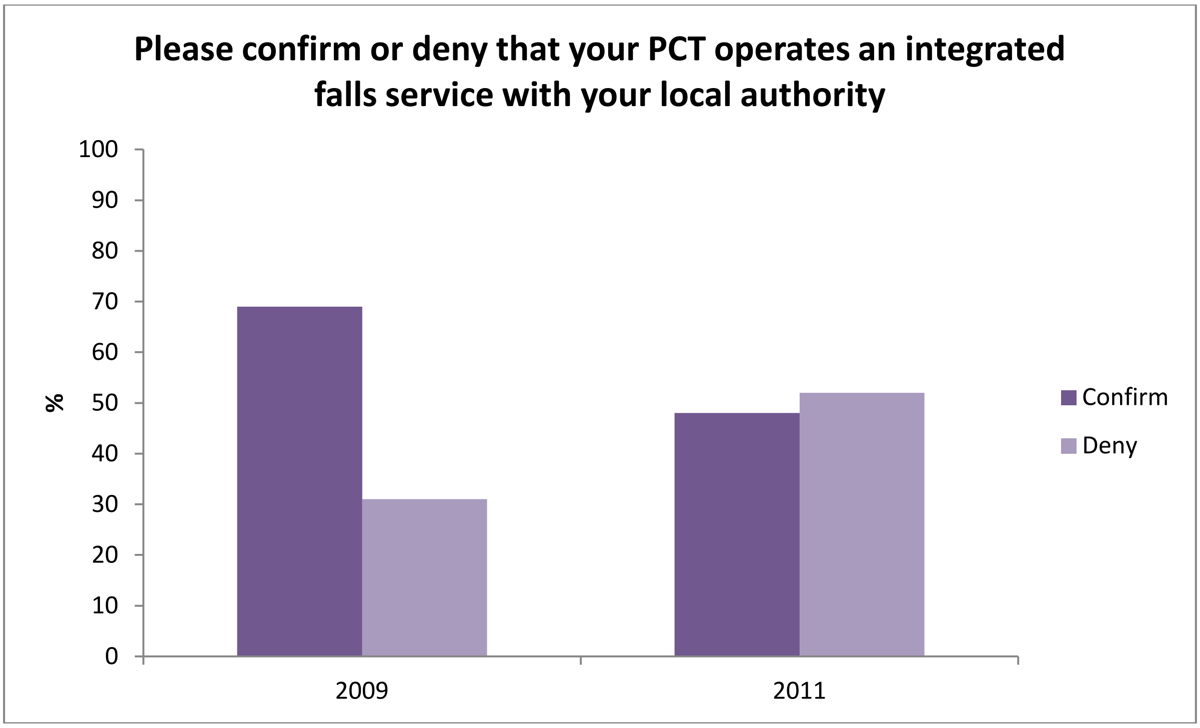
Recommendation 11: all PCTs and Clinical Commissioning Groups should ensure that patients with musculoskeletal conditions have access to a CATS and that their CATS are appropriately staffed

Working with local authorities

People with musculoskeletal conditions regularly need access to services provided by both the NHS and local authorities. The MSF acknowledged this by recommending the integration of falls services between local authorities to ensure the better management of osteoporosis.[lxxxii] Falls cost the NHS £4.6 million a day, and the concept of integrated services was first established in the 2001 National Service Framework for Older People.[lxxxiii]

Joint Working? uncovered evidence of continued delay in implementing integrated falls services with 31% of PCTs saying that they did not operate an integrated falls service.[lxxxiv] Responses to *Joint Delivery?* reveal that the situation has deteriorated further:

Figure 10: 2009/2011 comparison of the proportion of PCTs who operate an integrated falls service with their local authority



The 21% reduction in PCTs operating integrated falls services with their local authorities is of deep concern, and poses questions about the ability of health commissioners and local authorities to deliver integrated services – a key driver of the Government's health reforms. Reasons for this retrenchment in integrated working are not offered in responses to the audit, although tighter NHS and local authority finances could be a factor. If so, this is a false economy. Poor integration can result in a failure to manage conditions effectively, incurring greater downstream costs.

A number of PCTs who reported that they did not operate an integrated service said they did work across organisational boundaries but that the services were not formally integrated. NHS East Sussex Down and Weald for example said it has:

"A jointly agreed Falls and Bone Health Strategy 2010-13 that promotes service improvement to the whole falls pathway; there are a few services that work in close partnership across organisational boundaries to deliver falls support, however they are not integrated."[lxxxv]

Some PCTs said that they were in the process of reviewing their falls service and were in the process of looking to commission a new service. NHS Kingston for example said:

"A small falls service is provided by health - this is in the process of being reviewed and a new service model established in line with best practice (which will go live in autumn 2011)."[lxxxvi]

Six years after the deadline for PCTs to implement an integrated falls service, and two years after our audit exposed continuing delays in the implementation of integrated services, it is troubling to find that integrated working has gone into reverse. Some PCTs have implemented the programme, NHS

Oxfordshire in its response noted that it had been operating its integrated falls service since 2004.[lxxxvii]

In addition there were examples of PCTs who have embraced the integrated delivery model and are pioneering cross organisational work in this area. NHS Luton for example commented that:

" (Our) integrated falls service linking East of England ambulance services with an integrated falls team who go out and assess non traumatic falls which initiate referrals into local clinical services and/or access social service interventions including providing equipment etc. Also developing training with residential and nursing homes and will be developing a more robust care pathway with L&D Hospital and maintenance programmes ie. referrals onto exercise programmes with both the local authority and voluntary groups."[lxxxviii]

Such cross organisational working is to be commended and we feel that all health commissioners could benefit from such joint working. It is also important that the right groups are involved in the delivery of falls services. Occupational therapists have an important role to play in the Falls management services, both in prevention and in dealing with the consequences of falls and so should be consulted over the integration of Falls services.

Case study

Pennine Musculoskeletal (MSK) Partnership was established in 2002 as a triage service for rheumatology referrals which is run by NHS Oldham PCT and delivers a very successful service diverting 50% of GP referrals away from hospital. In March 2006 Pennine MSK Partnership began community based services with common referral entry for all MSK problems. The challenge was to develop a Programme Budget so that commissioning spend could be combined into one single integrated budget for MSK services as a way of maximising the value of commissioning spend. Using a combination of programme budgeting and marginal analysis Pennine MSK Partnership has developed a framework to help commissioners make, track and evaluate health investment decisions. The focus on commissioning has changed from measuring activity or process to measuring health gain. They are currently developing a way of displaying performance of the entire programme across the whole pathway using dashboard metrics which, once complete, will give a very valuable overview of how commissioning spend is used linked to health gain outcomes so the effectiveness – and value for money – of specific services can be assessed.

Recommendation 12: PCTs and clinical commissioning groups should work with local authorities through the introduction of health and wellbeing boards to integrate their falls service with the local authority

Access to secondary care

Traditionally patients with musculoskeletal conditions have had to endure some of the longest waiting times for hospital care. There is growing evidence that waiting times are increasing. For example in the trauma and orthopaedics area the percentage of people seen within 18 weeks has fallen from 87.6% this time last year to 83.4% this year.[lxxxix]

The MSF highlighted the importance of the 18 week waiting time target in delivering improved services for musculoskeletal patients.

Roche and Chugai Pharma UK have funded an agency to draft and produce this report and have checked its contents for factual accuracy. Editorial control rests with ARMA

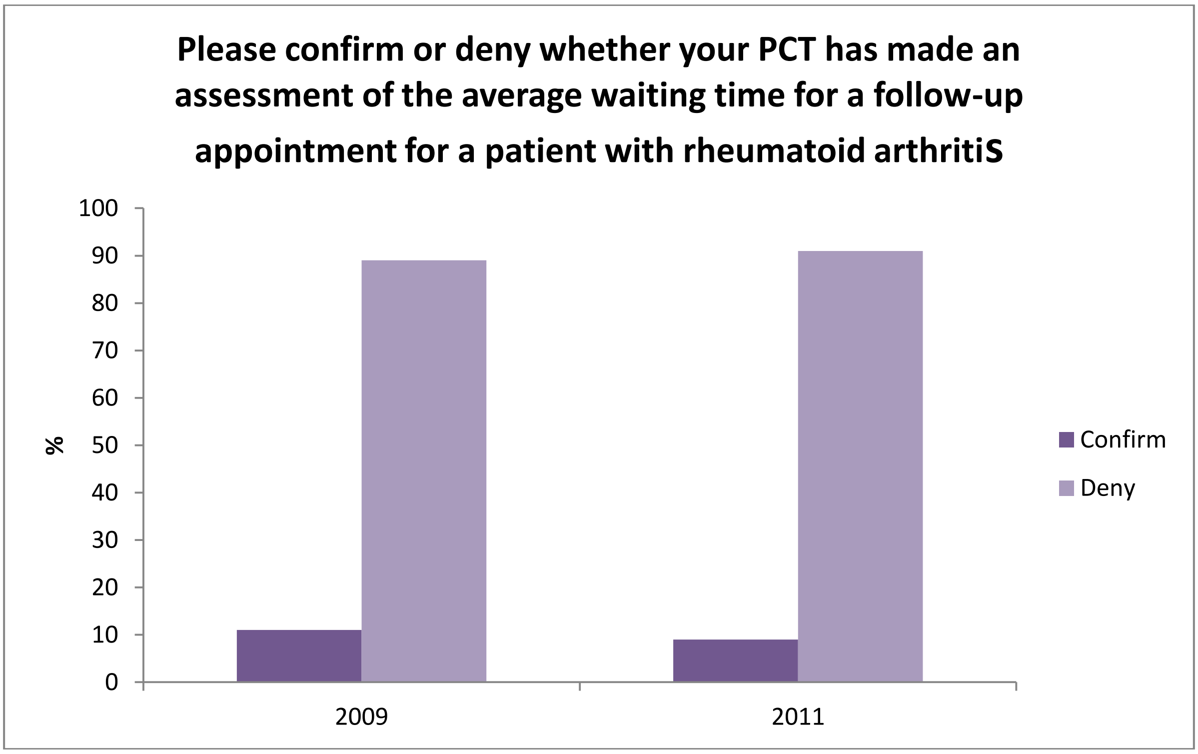
"Reshaping services in line with the Framework will assist in the delivery of improved access. For those patients needing hospital treatment, by the end of 2008 patients will be waiting no longer than 18 weeks from GP referral to the start of hospital treatment."[xc]

In addition to getting a timely initial referral for treatment, follow-up appointments play an important role in managing patients with musculoskeletal condition, ensuring that patients get access to high quality care and support:

"Following discharge, there should be an agreed process to ensure continued rehabilitation when needed, along with effective follow-up arrangements that identify and deal with complications, including late complications."[xci]

Joint Working? found that 89% of PCTs had made no assessment of the average waiting time for a follow-up appointment for a patient with rheumatoid arthritis.[xcii] Responses to *Joint Delivery?* reveal an even worse situation with only seven of the 80 PCTs who addressed the question in their response, saying that they had made an assessment.

Figure 11: 2009/2011 comparison of proportion of PCTs assessing the average waiting time for a follow up appointment for a patient with rheumatoid arthritis



Joint Working? found a significant number of PCTs focused on the 18 week waiting time target for initial treatment, arguing that this was the only appointment that was mandated to be monitored at either a national or local level.

Responses to *Joint Delivery?* demonstrate that commissioners continue to focus on the initial waiting time for treatments rather than on monitoring follow-up appointments. NHS Telford and Wrekin summed up the position of many PCTs:

"[the PCT] Reviews waiting times for all services at performance meetings with providers including waiting times for appointments; not specifically assessed average waiting time for follow up appointment."[xciii]

Similarly Worcestershire PCT said:

"Average waiting times for f/up appts is not routinely available but PCT does monitor waiting times for rheumatology services: 18-week pathway admitted and non-admitted - see attached file for performance."[xciv]

Some PCTs who said that they had not conducted an assessment said that they had conducted broader assessments. NHS Southampton City for example said it had undertaken an assessment:

"Not for RA specifically, have done for community based rheumatology service; as of April 2011, the average waiting time for this service is 15 weeks."[xcv]

Some PCTs – such as NHS Torbay Care Trust – said that they were looking to collate waiting times for follow-up appointments. None of the five PCTs who had said they were conducting assessments of these waiting times at the time of the last audit could confirm that they had completed such an assessment.[xcvi]

More positively, of those PCTs who had assessed their waiting times, it does appear that waits have fallen from those found at the time of the initial audit, though across the country a variable picture emerges. For example NHS Doncaster said that the result of its latest spot audit had uncovered a five week wait,[xcvii] whilst NHS Peterborough said that it was taking action to reduce its follow-up waiting times for rheumatology patients from its current level of 8-10 weeks, to 2-4 weeks.[xcviii]

The findings show that collating data on waiting times for a follow-up appointment is an important step in the process of reducing waiting times. However the responses indicate that many are still failing to follow NICE guidance.

Achieving short waiting times is an important part of delivering high quality clinical services. For example, the NICE clinical guideline on rheumatoid arthritis recommends that:

"In people with recent-onset active RA (key components of disease activity should be measured) monthly until treatment has controlled the disease to a level previously agreed with the person with RA."[xcix]

New commissioning groups should use these standards as a benchmark for effective commissioning of such services.

Recommendation 13: the national commissioning board should require clinical commissioning groups that fail to satisfy the 18-week referral to treatment standards to produce a plan to improve timely access to treatment and report against this plan

Recommendation 14: PCTs and clinical commissioning groups should carry out assessments of the average waiting time for a follow-up appointment for rheumatoid arthritis to ensure patients are getting access to the follow-up care they need to help them manage their condition

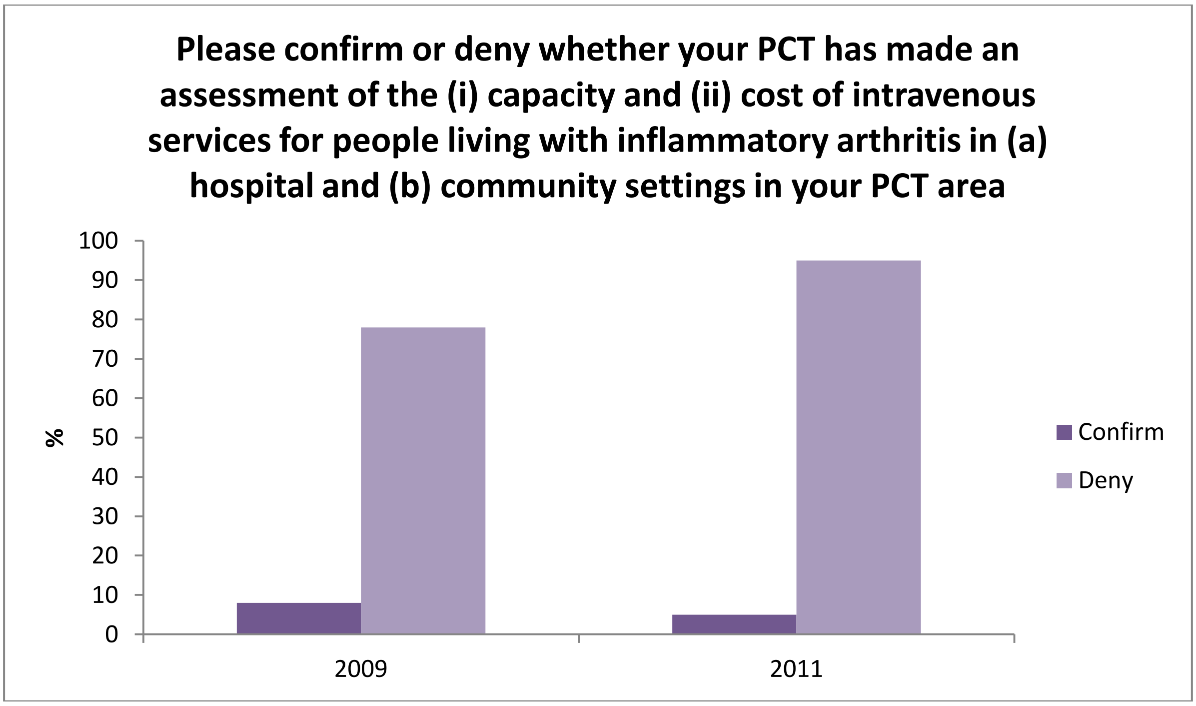
Recommendation 15: building on the commitment for NICE to develop quality standards for musculoskeletal conditions, NICE should prioritise these standards based on the absence of and adherence to existing guidance

Addressing capacity constraints

The development of new treatments for musculoskeletal conditions, many of which are delivered by infusion, create new opportunities to improve health outcomes, but also pose challenges to NHS capacity. It is therefore important that commissioners plan to have sufficient capacity available to enable patients to receive treatment at the optimal time. *Joint Working?* found that only 8% of PCTs had undertaken any assessment of the capacity and cost of intravenous services in either a primary or secondary care setting.[c]

PCT responses to *Joint Delivery?* reveal that the situation has deteriorated over the last two years with only four PCTs confirming that they had carried out such an assessment.

Figure 12: 2009/2011 comparison of proportion of PCTs who have carried out an assessment of the capacity and cost of intravenous services for people living with inflammatory arthritis in hospital and community settings



This finding is deeply concerning and will be of concern beyond the musculoskeletal community given that commissioners should be undertaking capacity planning for intravenous services in other disease areas, such as cancer.

With the pressure on services likely to increase as a result of the need for efficiency savings, as well as the increasing availability of new treatments, it is crucial that commissioners undertake assessments of the capacity and costs of intravenous services in both primary and secondary care, to ensure that patients get access to the treatments they need. Poor capacity planning and long waits for treatment are likely to result in poorer patient outcomes and higher costs per patient in the longer term.

Some commissioners did indicate that they were looking to develop a more accurate picture. NHS Torbay, for example, replied saying:

"Have requested this information from the provider; some information has been provided on drug costs but further work needs to be done to understand the total cost - this is a priority in the health community and is being taken forward via appropriate forums."[ci]

NHS West Hertfordshire added that "*work is underway as part of Rheumatology Community Nurse Project*. "[cii]

The low number of commissioners undertaking capacity assessments again poses concerns about the ability of integration between primary and secondary care. The establishment of clinical commissioning groups should help address this and it will be important when new commissioners develop their commissioning plans that they undertake an assessment of the capacity and cost of intravenous services to ensure the effective commissioning of services.

Recommendation 16: PCTs and clinical commissioning groups should undertake an assessment of the capacity and cost of intravenous services as part of their commissioning plans to ensure there is sufficient capacity for patients to benefit from new treatments

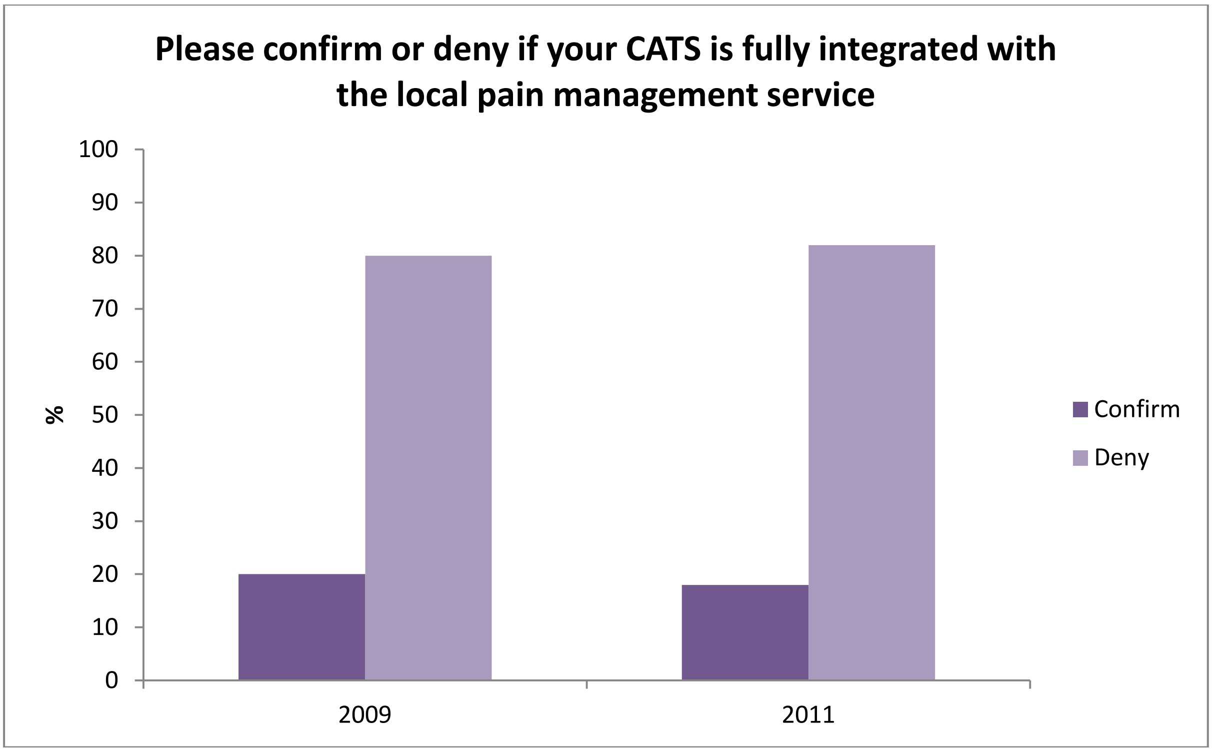
Pain management

Many musculoskeletal patients suffer from additional pain problems resulting from their condition and some suffer mental health problems as well.

Joint Working? found that only 20% of PCTs had integrated their CATS service with their local pain management service despite this being a recommendation of the MSF.[ciii]

PCT responses to *Joint Delivery?* reveal that the number has fallen to just 18% of PCTs.

Figure 13: 2009/2011 comparison of the proportion of PCTs operating a CATS integrated with the local pain management service



It is disappointing that no progress has been made since our first audit in the integration of CATS services and pain management services given the needs of musculoskeletal patients. Indeed some PCTs indicated that there was no integration at all, while others were only partly integrated.

NHS North East Essex, for example, said that its CATS was *"integrated for Back and Neck Pathway only."*[civ]

Many PCTs did not comment on integration, though some did note that they worked closely together. NHS Peterborough commented that: *"both operate from the same location which aids communication."*[cv] Whilst geographical proximity can aid integrated working, it is certainly not a substitute for a formally integrated system.

Some PCTs said that they were in the process of developing a more integrated service for musculoskeletal patients. NHS West Sussex for example said that it is:
"Currently developing the specification for an integrated MSK service that covers rheumatology, orthopaedics and pain management within the same service."[cvi]

NHS Tameside and Glossop said that it was redesigning its musculoskeletal service and would ensure that CATS would be *"incorporated into this."*[cvii]

Recommendation 17: as part of their assessment of their CATS service PCTs and clinical commissioning groups should integrate the service with their local pain management service

Supporting people to remain in work

Musculoskeletal conditions are the second biggest cause of work-limiting health problems and sickness absence in the UK.[cviii] ARMA's *Work Charter* launched in 2009 called for action to help people with musculoskeletal conditions remain in work. Specifically it called on:

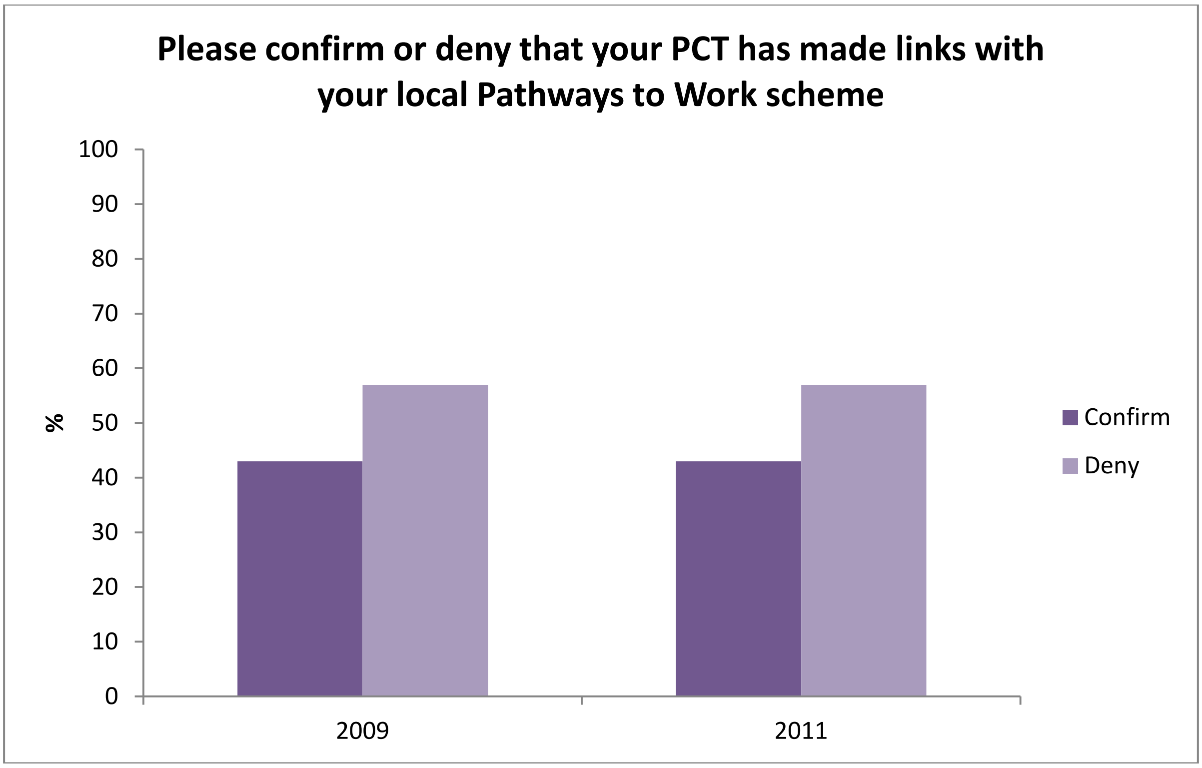
- Policymakers to prioritise musculoskeletal conditions through the introduction and implementation of national-level policies
- Employers and workplaces to understand and address the needs of employees with musculoskeletal conditions
- Healthcare providers to re-focus on the 'capacity' of their patients, and to take responsibility for providing work-focused health advice and support or referring to an appropriate specialist
- People whose lives are affected by MSDs to demand action and support from their Government, employer and healthcare provider[cix]

Joint Working? found that a majority of PCTs had not made links with the previous Government's Pathways to Work programme, a scheme set up and available to everyone claiming incapacity benefits and Employment and Support Allowance from April 2008.[cx] Establishing a link with the Pathways to Work programme was another recommendation of the MSF.[cxi]

Although the programme ended earlier this year, keeping patients with long term conditions in work is a priority of the Government's health reforms with domain two of the NHS Outcomes Framework focused on improving the quality of life and outcomes for patients with long term conditions.[cxii] Therefore establishing links with other Department for Work and Pensions schemes that help people get back to work should remain a priority. In addition ensuring that patients have access to a range of support from occupational therapists and other healthcare professionals should be central to the back to work agenda.

Responses to our 2011 audit however reveal that no progress has been made with only 43% of PCTs, the same number as in *Joint Working?*, saying that they had established links with Pathways to Work:[cxiii]

Figure 14: 2009/2011 comparison of proportion of PCTs who have made links with local Pathways to Scheme



Of greatest concern in the replies were those PCTs who admitted that they had not heard of the Pathways to Work programme. NHS Bolton for example replied saying:

"Not aware of Pathways to Work, but do support events through Clock into Health a local scheme to work with employers through the public health department."[cxiv]

This is unlikely to be an isolated case, as there appeared to be a broader lack of knowledge amongst PCTs about Pathways to Work. Two PCTs – NHS Halton and St Helens and NHS Knowsley – said that they were making progress in establishing links with Pathways to Work adding that *"firmer links being established via a new post presently being proposed which will include signposting for vocational rehab."*[cxv] [cxvi] Given that the Pathways to Work programme has now ended and thus no such links can be made formally with it, such answers demonstrate the obstacles to working across different areas in the delivery of co-ordinated and integrated care and support for musculoskeletal patients.

Some of those who denied links with Pathways to Work were aware of the ending of the programme and pointed to this as the reason for not establishing links, however they did not say whether they had made any links during the time that it had been running.

Indeed regardless of the ending of the formal programme, PCTs should continue to engage with organisations and schemes that are in place to help get people back to work. Some, such as NHS West Cheshire, indicated that they were doing so and said they were continuing to work *"with Job Centre Plus and their commissioned pathway provider."*[cxvii] NHS Peterborough displayed a forward thinking approach to integration in this area noting that the "*Local Jobcentre Plus Partnership*

Manager attends the Carers Partnership Board, the Learning Disabilities Partnership Board and the autism sub-group."[cxviii] There is also an important role for GPs to play when assessing patients and ensuring that they proactively ask about a patient's work status during consultations and new GP commissioners should consider assessing such a measure as part of their commissioning plans.

Recommendation 18: PCTs and clinical commissioning groups should develop partnerships with organisations and schemes to support musculoskeletal patients to stay in or return to work

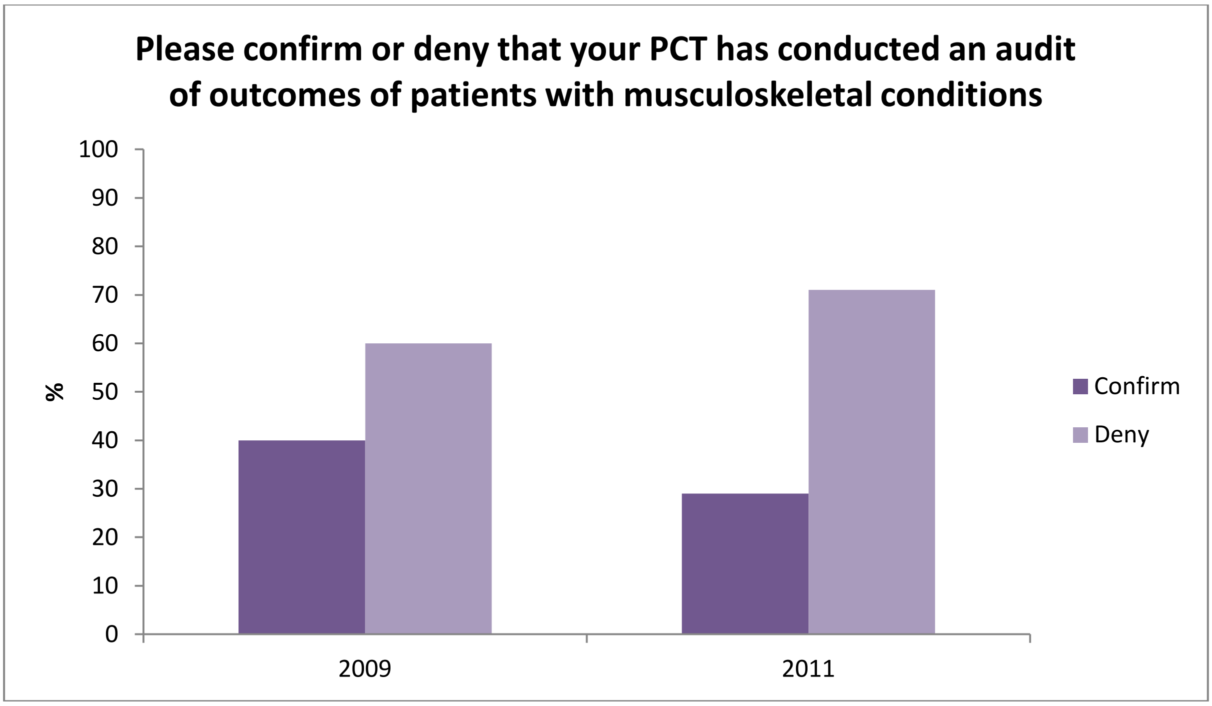
Recommendation 19: health and wellbeing boards should ensure that local health and local authority commissioners of public health, health and social care services develop partnerships with back to work schemes for musculoskeletal patients

Outcome measures

The MSF noted the importance of PCTs identifying outcome measures and referring to agreed protocols and standards of care. However, beyond patient satisfaction measures, there were very few specific measures listed.[cxix]

Joint Working? found that only 40% of PCTs had conducted an audit of outcomes of patients with musculoskeletal conditions.[cxx] Our updated audit uncovers a reduction in PCTs auditing the outcomes of patients with musculoskeletal conditions.

Figure 15: 2009/2011 comparison of the proportion of PCTs conducting an audit of outcomes for patients with musculoskeletal conditions



This reduction in the number of PCTs auditing the outcomes of people with musculoskeletal conditions is troubling given the emphasis the Government's health reforms place on improving outcomes for patients. It will be crucial that new clinical commissioning groups develop a set of outcome measures for musculoskeletal patients to monitor their performance as musculoskeletal commissioners and to ensure patients are getting the best treatment and care they can.

Of those PCTs that had developed agreed outcome measures, there was a wide variety in the type of measures chosen. As in *Joint Working?,* our updated audit finds that some PCTs continue to select the 18 week waiting time target (amongst others) as a measure of patient outcomes, despite the data gathered not reflecting patient satisfaction or clinical outcomes. Similarly NHS Bradford and Airedale noted that one of its outcome measures was an audit of referrals to specialists to ensure "relevance".[cxxi]

Some PCTs – such as NHS Brighton and Hove – said that it was developing outcome measures,[cxxii] whilst NHS County Durham said that the development of outcomes measures was being picked up by the pathfinder consortia prioritising musculoskeletal conditions in their area.[cxxiii]

Of those PCTs who had identified outcome measures, there was a wide variety of measures used including:

- Patient Reported Outcome Measures (such as EQ5D)
- Roland Morris disability questionnaire
- Patient experience survey findings

In addition, commissioners used a number of existing data collection categories to assess patient outcomes, including admission and re-admission rates and bed days of care for musculoskeletal patients. The wide variety of outcomes measures adopted by commissioners makes it difficult to compare the performance of commissioners in their commissioning of musculoskeletal services. The Department of Health should consider developing a set of standard outcome indicators for musculoskeletal conditions and include these in the forthcoming NHS Outcomes Framework.

ARMA has worked with its individual members to develop a set of outcome measures which should be considered in this process (see annex 1).

Case study

Ashton, Leigh and Wigan Primary Care Trust (PCT) has produced a contract specification as part of a service redesign for rheumatology. Specific commissioning metrics, developed by Commissioning for Quality in Rheumatoid Arthritis (CQRA), have been incorporated into the specification as key performance indicators (KPIs) in order to define and monitor the quality of RA service provision within the PCT. The benefit of incorporating clinically-relevant KPIs into the contract specification is that commissioners are able to set a target of quality improvements for providers. If these KPIs are met by providers they provide evidence of good quality service provision and demonstrate the appropriate use of commissioning budget. Conversely, where KPIs are not achieved, the contract specification allows for a proportion of the contract value to be withheld, through appropriate use of penalties, providing a strong incentive for KPIs to be met. Data from the KPIs can be used to better understand the pattern of service allowing areas for service improvement to be identified and specific goals to be set to monitor and measure improved service delivery.

Recommendation 20: the Department of Health should develop a set of standard outcome indicators for musculoskeletal conditions and include these in the next NHS Outcomes Framework

Addressing variation

Joint Working? found a thirteen fold variation in expenditure between PCTs on treating musculoskeletal patients. Whilst some variation is to be expected, this level of variation was concerning as it cannot be justified by differences in health need alone.

An updated analysis by ARMA of Department of Health programme budgeting data reveals that expenditure on musculoskeletal services has increased at a faster rate than overall NHS expenditure (16% from 2007-08 to 2009-10 compared to 11% overall)[cxxiv] and it is not clear that this increase in expenditure has delivered the improvements required by either patients or the taxpayer.

Significant variation in the level of expenditure by individual commissioners also persists. Despite the overall increase, almost a fifth of PCTs spent less on musculoskeletal services in 2009-10 compared to 2007-08, with three PCTs reducing expenditure by over a quarter (NHS South Tyneside, NHS Peterborough and NHS Waltham Forest).[cxxv]

The analysis reveals notable variations in expenditure per patient. Expenditure in 2009-10 ranged from £275 per patient per year in NHS Peterborough, to £764 per year per patient in NHS Hartlepool. [cxxvi] A significant number of PCTs (33) reduced their investment in musculoskeletal services per patient between 2008-09 and 2009-10.[cxxvii] NHS Barnet spent 41% less per patient, while NHS Hammersmith and Fulham increased spending by 170%.[cxxviii] The gap between highest and lowest spending PCT has also increased slightly from 2008-09 to 2009-10.

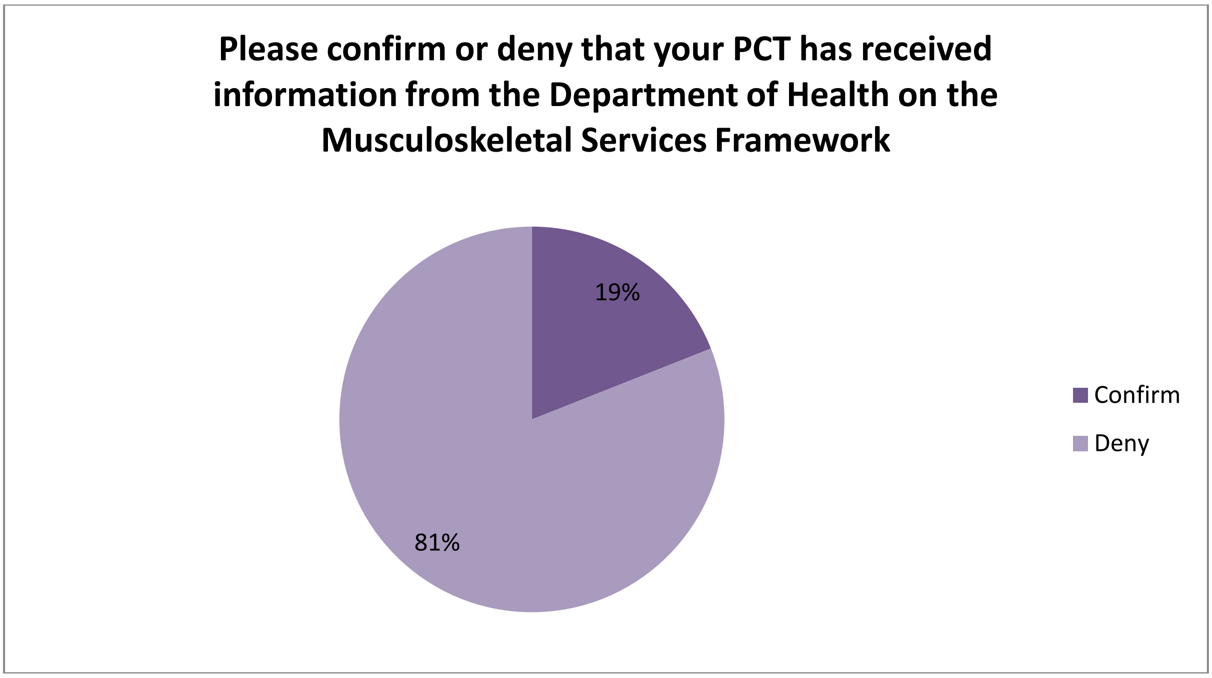
These variations indicate that there are:

- Significant inequalities in expenditure on musculoskeletal services, potentially caused by inadequate or inaccurate assessments of local needs
- Variations in the cost and efficiency of services
- Unacceptable inaccuracies in coding or recording of expenditure, resulting in commissioners being provided with misleading information on expenditure

Irrespective of the reason, it is clear that stronger commissioning is required.

The lack of progress in addressing variations in expenditure is not surprising given the lack of mapping of resource allocation and outcomes audits undertaken by PCTs outlined earlier. However it also reflects a lack of awareness among many commissioners of existing guidance on delivering effective musculoskeletal services, and the lack of application of the recommendations from the MSF. This is reflected in the small number of PCTs who reported receiving information on the MSF and its recommendations from the Department of Health:

Figure 16: Proportion of PCTs who have confirmed receipt of information from the Department of Health on the Musculoskeletal Services Framework



Less than one in five PCTs said that they had received information from the Department of Health on the MSF. In addition less than one in four (24%) said that they had received information from their Strategic Health Authority on the framework. Whilst the framework was published in 2006, it remains the latest guidance from the Department on how care for patients with musculoskeletal conditions is delivered and should be being used as a reference tool by commissioners when commissioning musculoskeletal services.

Many PCTs, such as NHS Bedfordshire, said that they were not aware of having received information from the Department on the framework.[cxxix] More encouragingly others who said that they had not received formal information were still continuing to use guidance from the framework to effectively commission services.

NHS Doncaster said that, whilst it had not received formal communication from the Department, it was using the MSF to redesign its care pathways for patients with musculoskeletal conditions.[cxxx] Similarly NHS Bolton said that all its musculoskeletal services were commissioned and delivered on the basis of the framework.[cxxxi] NHS Leeds said it was consulting the framework in redesigning care pathways.[cxxxii]

It is concerning that five years after the publication of the MSF, there has been little formal communication between the Department of Health and commissioners on the MSF. This means that so far there has been no attempt to translate the NHS reform agenda for commissioners and providers responsible for the provision of musculoskeletal services. Some commissioners continue to use the framework to inform the planning and delivery of musculoskeletal services, showing the importance of setting out a national approach to improving musculoskeletal services and effective service provision. Five years after the MSF there is not only a need for the Department to better promote existing guidance but to publish new guidance in the form of a national outcomes strategy for musculoskeletal services to ensure that musculoskeletal services are a priority for commissioners.

Partly as a result of the work undertaken by ARMA through the *Musculoskeletal Map of England*, the Department of Health in November 2010 published its Atlas of Variations report which looked at variations in levels of service provision and expenditure across England.

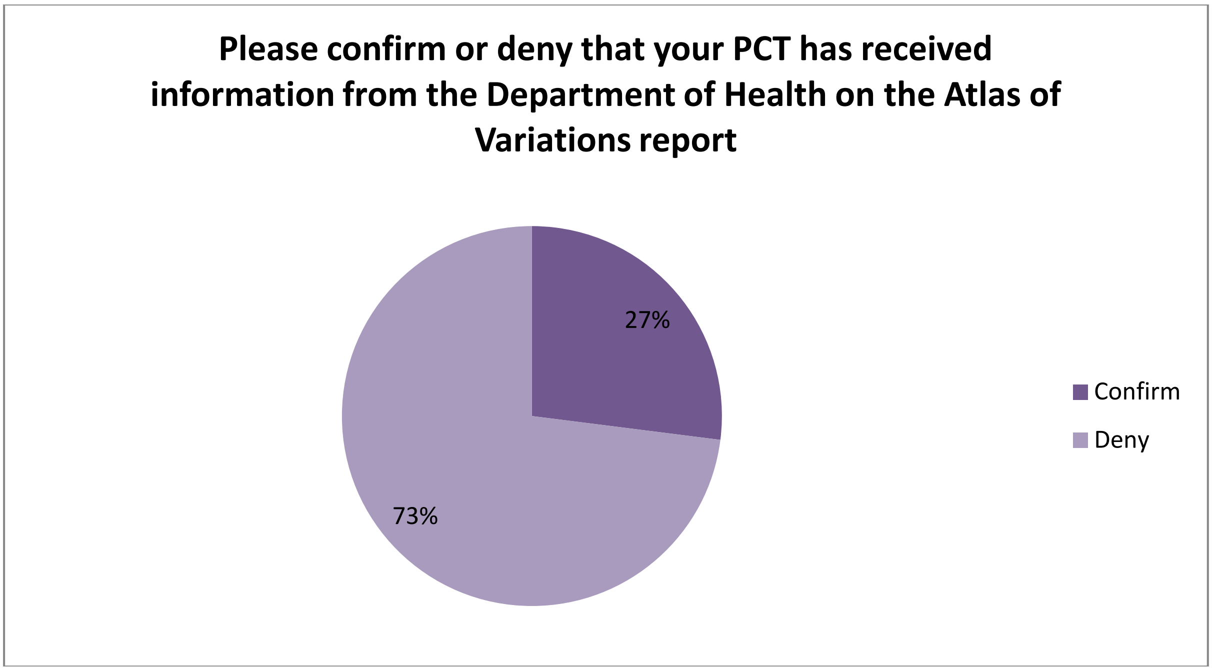
The Atlas contained information on variations in musculoskeletal services and found:

"variation among PCTs in musculo-skeletal expenditure is almost threefold, ranging from just over £40,000 per 1000 population to almost £120,000 per 1000 population. When the five PCTs with the highest rates of expenditure and the five PCTs with the lowest rates of expenditure are excluded, the variation is still greater than twofold. The degree of variation in investment in musculo-skeletal services does not reflect the variation in the incidence, prevalence or severity of osteo-arthritis or rheumatoid arthritis. "[cxxxiii]

The Atlas also found major variations in hip replacement rates among geographical areas that could not *"be explained solely by differences in need."*[cxxxiv] The Atlas found a 14 fold variation in the rate of provision of hip replacement by local authority boundary and a 16 fold variation in the rate of expenditure for cemented primary hip replacement per 1000 population.[cxxxv]

The Atlas also set out a series of recommendations for commissioners following its publication to assist them in addressing such unwarranted variation. However responses to our information request found that the Atlas is not necessarily being communicated clearly to commissioners.

Figure 17: Proportion of PCTs who have received communication from the Department of Health on the Atlas of Variations



Only 24 PCTs - just over a quarter of those who addressed this question in their response - said that they had received communication from the Department of Health on its Atlas of Variations report. Some PCTs said that whilst they had not received formal communication on the Atlas they were aware of its existence, through online bulletins and others had said that they had downloaded it from the Department of Health's website. However this lack of formal communication between the Department and commissioners is troubling and poses wider questions as to the way advice and guidance from the Department is disseminated.

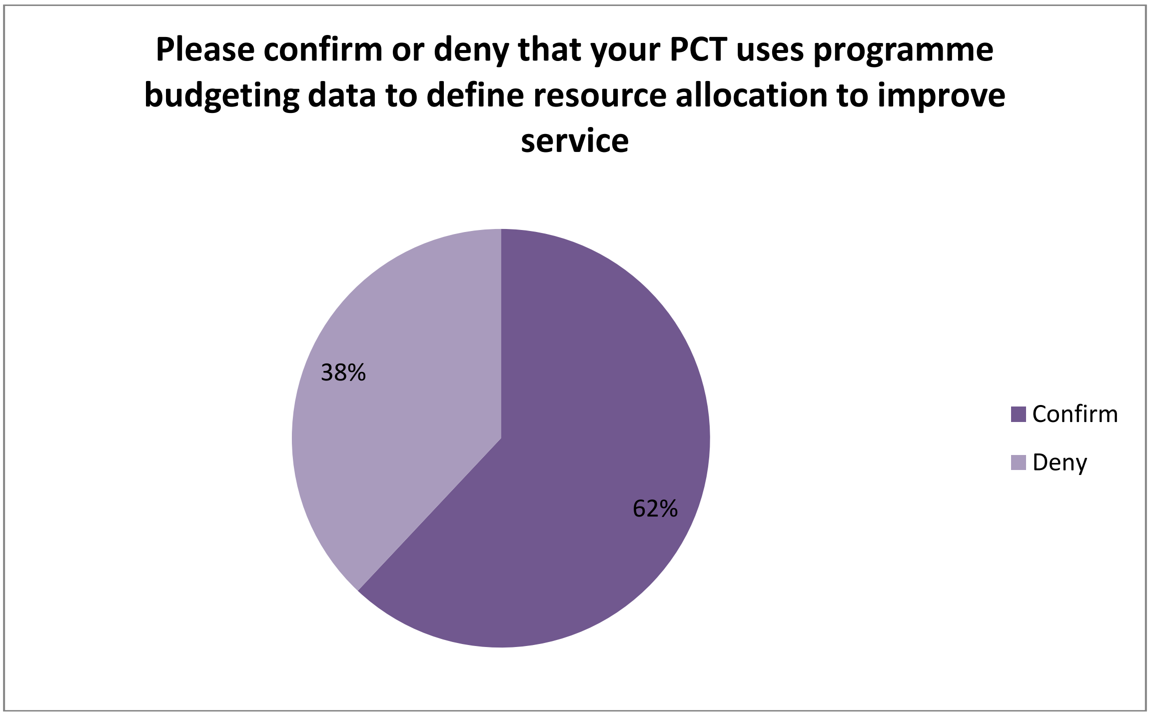
The way the Atlas is being used varies greatly between commissioners. Positively, 24 PCTs said that they had undertaken reviews of spending on musculoskeletal services as a result of the Atlas. Interestingly, these 24 were not necessarily the same PCTs who had received formal communication from the Department on the Atlas. In addition some PCTs, such as NHS Trafford and NHS Oxfordshire, said that reviews were already underway before the Atlas was published.[cxxxvi] [cxxxvii] Others, such as NHS Nottinghamshire, said that they had convened a working group to see how they could get more value from the musculoskeletal services budget.[cxxxviii]

However other commissioners were less engaged with the Atlas and its implications. NHS Leeds said it was reviewing all care pathways including for musculoskeletal services, though added that this was not related to the Atlas of Variations.[cxxxix] NHS West Hertfordshire simply stated that as there were: *"no instructions issues in bulletin, no actions (were) being taken as a result of bulletin being received."*[cxl]

Some PCTs, such as NHS Croydon, stated that they were unable to act on musculoskeletal expenditure as a result of not holding the pre-requisite information despite all PCTs collecting such data as part of their programme budgeting data requirements.[cxli]

Programme budgeting data provides PCTs with an opportunity to benchmark their spending on twenty-one conditions, including musculoskeletal conditions, against other commissioners which can provide invaluable insights into the effectiveness of their resource allocation methods and the effectiveness of their services for patients. However, responses to *Joint Delivery?* reveal that many commissioners are not utilising programme budgeting data in this way:

Figure 18: Proportion of PCTs who use programme budgeting data to define resource allocation to improve service



54 PCTs who addressed the question said that they did use programme budgeting data to define resource allocation to improve service. However 32 PCTs said that they did not, raising questions as to how commissioners are auditing expenditure on certain conditions and how they are able to commission services effectively. NHS Bradford and Airedale, for example, said that it did not have specific plans to use programme budgeting data to support service redesign in musculoskeletal services.[cxlii] NHS Bolton said that it used programme budgeting data to inform service delivery but said that it did not do so for musculoskeletal services.[cxliii]

Of those who said that they did use programme budgeting data, many saw it as an essential tool to inform service development.

NHS Suffolk said that it used Programme Budgeting Data as part of its *"annual priority setting process,"*[cxliv] whilst NHS Bedfordshire said that it had used such data for the last two years to inform service delivery.[cxlv] Specifically for musculoskeletal services NHS Warrington stated that its *"service reviews utilised Atlas of Variation and Programme Budgeting data for MSk - this enables bench-marking expenditure against similar organisations."*[cxlvi]

Others, such as NHS Torbay, said that they did use programme budgeting data along with other *"benchmarking and comparative tools."*[cxlvii]

Given the significant variations in expenditure outlined earlier in the chapter concerning spend per head of population on musculoskeletal conditions, it is important that commissioners utilise tools at their disposal such as programme budgeting data to effectively benchmark their resource allocation against other commissioners. Such an exercise will have two marked benefits:

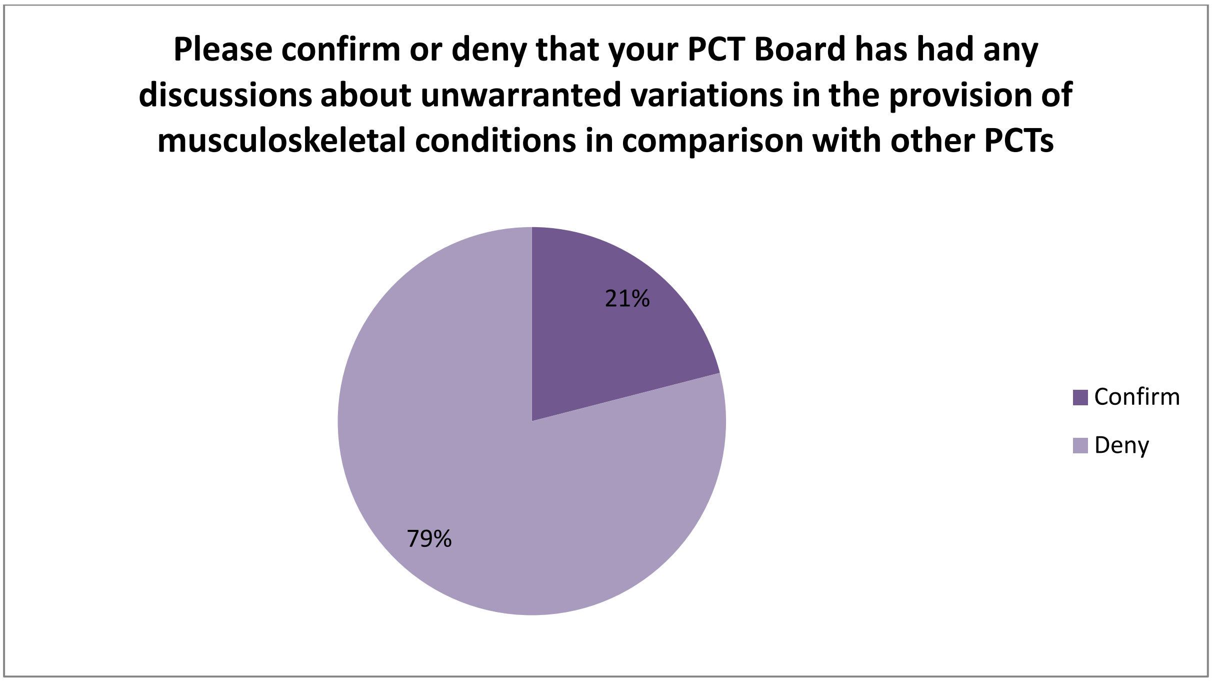
- For those commissioners spending a higher than average amount on musculoskeletal services it should lead them to examine whether their services should be redesigned to make them more efficient and effective

- For those commissioners spending a lower than average amount on musculoskeletal services it should result in them analysing whether their spend is sufficient to meet the needs of their population

Both outcomes would help address variations in service provision between areas, improve efficiencies in services and result in improved outcomes for patients.

However, only 17 PCTs who responded to our audit said that they had had board level discussions about variations in the provision of musculoskeletal conditions in comparison with other PCTs.

Figure 19: Proportion of PCTs holding board discussions on unwarranted variations in the provision of musculoskeletal conditions in comparison with other PCTs



Of those who had had such conversations, the nature of the discussion topics varied. NHS Bournemouth and Poole said that it discussed variations in spending on musculoskeletal services in relation to the Department of Health's Quality, Innovation, Productivity and Prevention (QIPP) initiative.[cxlviii] Encouragingly NHS West Sussex said that variations in musculoskeletal conditions were actively being discussed by the Boards of pathfinder clinical commissioning groups in its area.[cxlix] NHS Ealing attached a paper that was presented to its executive committee on variations in musculoskeletal service provision and the need to improve services.[cl]

60 PCTs said that there had been no discussions at Board level about musculoskeletal conditions. NHS Coventry said that there had been no discussions in *"the last two years"*, whilst NHS Heart of Birmingham said no discussions had taken place as no unwanted variations in service provisions had been noted.[cli] NHS Stockport said that as musculoskeletal services were *"not a priority area [that] this had not been taken to the Board."*[clii]

Recommendation 21: PCTs and clinical commissioning groups should undertake an assessment of their programme budget spend in relation to musculoskeletal conditions and the NHS Commissioning Board should benchmark this spend against other commissioners to ensure adequate resource is being spent on musculoskeletal conditions in their area

Recommendation 22: the Department of Health should ensure that all PCTs and clinical commissioning groups are aware of existing guidelines on musculoskeletal conditions including the MSF and Atlas of Variations report

Recommendation 23: PCT and clinical commissioning group boards should collect data on clinical outcomes as well as PROMs and PREMs and use this to inform the way that services are commissioned

Chapter 8: managing the transition

The NHS is changing. The reform proposals present opportunities to improve the quality of musculoskeletal services, with the new levers in the system - based on improved outcomes, patient choice, information, clinically-led commissioning, and integration - creating opportunities to drive up standards of care for patients.

ARMA strongly welcomes the increased focus on improving outcomes in the reforms. However, this focus now needs to be translated to a condition-specific level, if it is to be truly meaningful to patients or clinicians. For too long outcomes for patients with musculoskeletal conditions have not been a priority for the NHS. Musculoskeletal conditions cross all five domains of the new NHS Outcomes Framework.

How musculoskeletal services align with the NHS Outcomes Framework

Domain 1: Preventing people from dying prematurely – whilst not specifically referred to in the domain, improving care for those with musculoskeletal conditions will be important in achieving the overarching indicator: *mortality from causes amenable to healthcare*

Domain 2: Enhancing the quality of life for people with long term conditions – musculoskeletal conditions are relevant throughout the improvement areas of the domain, including *improving quality of life for people with long term conditions*, *reducing time spent in hospital for people with long term conditions* and *improving functional ability of people with long term conditions*

Domain 3: Helping people to recover from episodes of ill health or following injury – musculoskeletal conditions are relevant to the improvement areas: *helping older people to recover their independence following illness or injury* and *improving recovery from injury and trauma*

Domain 4: Ensuring people have a positive experience of care – musculoskeletal conditions are relevant across the improvement areas of the patient experience domain from primary care, to outpatient care to hospital care

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm – musculoskeletal conditions are relevant to the improvement area *reducing incidence of avoidable harm* in this domain

ARMA's work on outcome metrics (see Annex 1) will be helpful in ensuring that musculoskeletal services are aligned with this new form of accounting for performance.

Commissioning priorities

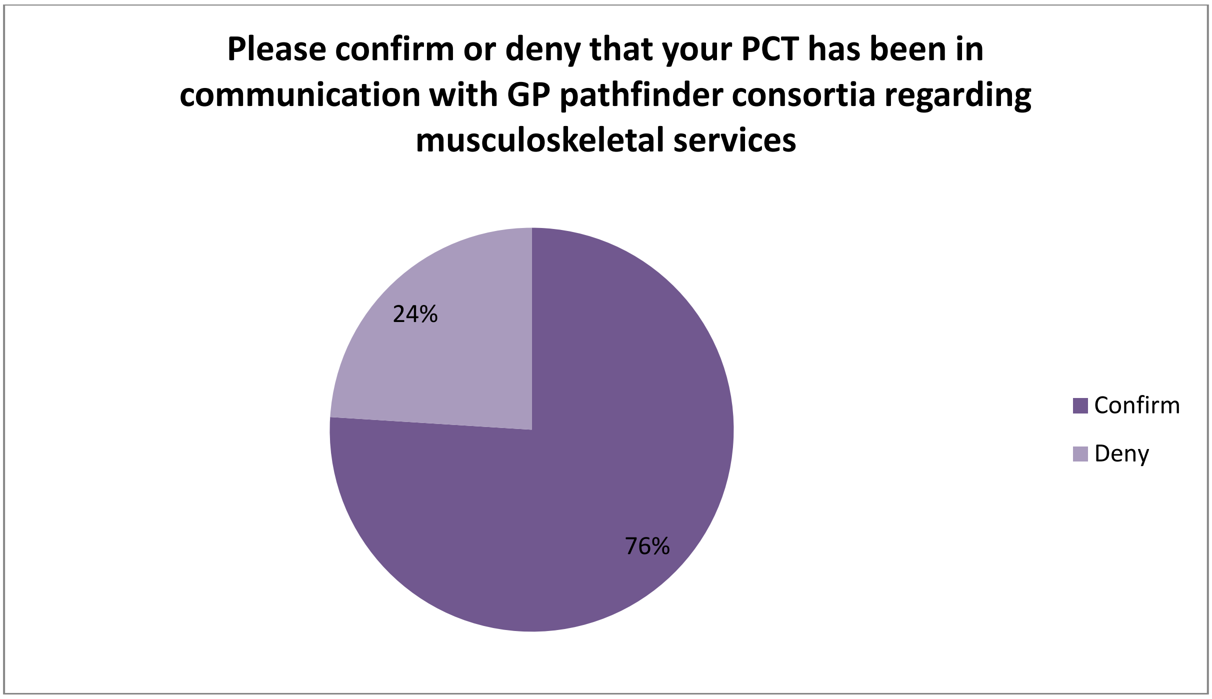
Joint Working? identified the lack of prioritisation of musculoskeletal services within the World Class Commissioning process as a barrier to effective commissioning.[cliii]

Although the world class commissioning process has officially come to an end, the creation of clinical commissioning groups presents an opportunity for musculoskeletal services to be prioritised in the new commissioning system. All new clinical commissioning groups are expected to identify

Roche and Chugai Pharma UK have funded an agency to draft and produce this report and have checked its contents for factual accuracy. Editorial control rests with ARMA

commissioning priorities. Our updated audit asked PCTs whether they had had any communication with pathfinder commissioning groups in their area about commissioning musculoskeletal services:

Figure 20: Proportion of PCTs engaging with commissioning groups regarding musculoskeletal services

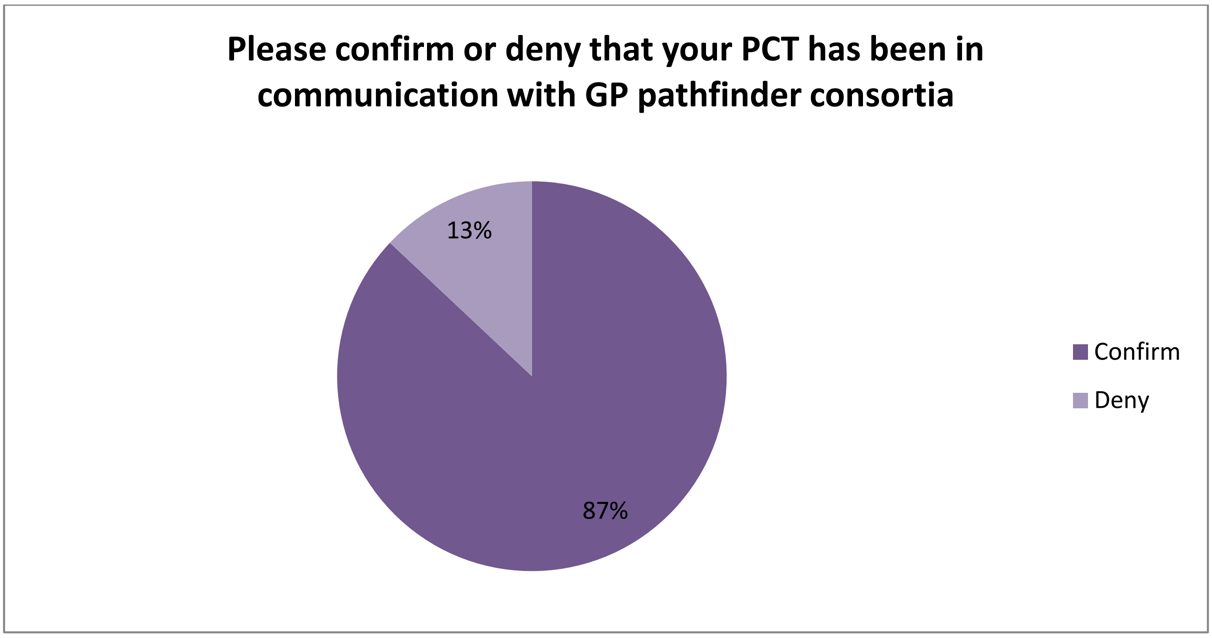


It is concerning that 24% of the primary care trusts who answered the question said that they had had no contact with new clinical commissioning groups in their area about musculoskeletal services. Some PCTs - whilst not formally communicating with the next generation of commissioners on musculoskeletal – were collaborating on related projects. NHS Peterborough said that GPs were leading the redesign of musculoskeletal services locally[cliv] whilst NHS Tameside and Glossop said that whilst it has not had any specific contact with pathfinder commissioning groups it has identified a commissioning lead to manage the *"pain management QIPP project."*[clv]

A number of PCTs said that they working actively with commissioners in emerging clinical commissioning groups in the delivery of musculoskeletal services. NHS West Sussex for example said that it had *"assigned staff to work with emerging GP consortia who communicate regularly regarding the integrated MSK service project."*[clvi] NHS Warrington said that pathfinder clinical commissioning groups were now in charge of commissioning decisions and that lead GPs have been fully involved in latest MSK review.[clvii]

More broadly, 12 PCTs said that they had had no communication at all with pathfinder commissioning groups in their area. This is concerning given the pace of the transition and the steps that need to be taken to ensure that clinical commissioning groups are prepared to assume their new responsibilities.

Figure 21: Proportion of PCTs communicating with clinical commissioning groups



More encouragingly six pathfinder clinical commissioning groups have identified musculoskeletal services as a commissioning priority.

Commissioners prioritising musculoskeletal conditions

Ealing Commissioning Consortium is prioritising the improvement of musculoskeletal conditions across its population of 360,000.[clviii]

Bracknell Forest, based in South Central SHA which is focusing on acute commissioning, musculoskeletal, cardiology, ophthalmology, urology, dermatology, gynaecology, community services and mental health. Bracknell Forest has a population size of 107,320.[clix]

Ipscom in Ipswich, based in East of England SHA has a population size of 161,000 and is focusing on a musculoskeletal education programme.[clx]

Wigan Commissioning Consortium based in North West SHA is focusing on commissioning for stroke, falls and dermatology. Additionally the consortium is focusing on medicines management, musculoskeletal services, diabetes, unscheduled care and scheduled care.[clxi]

It is certainly welcome to see a number of new commissioners prioritising musculoskeletal conditions in the new NHS. The Department of Health should engage with these groups to identify areas of good practice musculoskeletal commissioning which could be disseminated more broadly through the system.

ARMA has been hosting a series of workshops on the effective commissioning of musculoskeletal services and believes that there will be a number of areas in which new commissioners will require support in order to effectively commission musculoskeletal services. The recommendations are included in the following table.

Effective commissioning of musculoskeletal services – recommendations

1. Unwarranted variations of service provision and quality can best be tackled by encouraging commissioners to use high quality, contextualised data
2. Commissioners should draw on the expertise of a range of groups including: lead clinicians from consortia, Allied Healthcare Professionals (including physiotherapists), directors of public health, social care representatives, local finance directors, representatives from relevant specialists (including orthopaedics and rheumatologists) and patient representatives when interpreting data on musculoskeletal services
3. Existing sources of information on musculoskeletal services are fragmented and should be brought together in one location for convenience of access for commissioners
4. There is a strong case for asking a Public Health Observatory to become the lead supplier of information on musculoskeletal services and develop commissioning information packs. Alternatively, an information network could be created to ensure access to high quality information
5. Data are only as effective as the interpretation they lead to and the actions that result. In order to support this, commissioning information packs should include a commentary setting out potential explanations for findings as well as the limitations of data sources
6. A range of organisations including health and wellbeing boards, local Healthwatch, patient groups and the wider public should be encouraged to play a role in facilitating public and patient involvement in the communication of musculoskeletal services. There is a role for external organisations in supporting these bodies, as they seek to play an active role in developing communication policies for musculoskeletal conditions
7. In implementing the policies of Any Qualified Provider it will be important to ensure continuity of care across the care pathway. Potential mechanisms for delivering this include: integrated networks, a prime vendor model, a multiple prime vendor model and a local musculoskeletal care system
8. Irrespective of the model adopted it will be important that commissioners and providers operate fairly according to established principles around competition, choice, information, quality, efficiency, training and clinical trials and that contracts include break clauses in case of poor service delivery
9. Facilitating informed choice should be a key role for effective commissioners. In ensuring that patients are able to make an informed choice, commissioners should take measures to enable patients to have access to the following tools: decision aids, information prescriptions, voluntary sector advice and personal care planning tools
10. The NHS Commissioning Board should support consortia by developing a range of financial and non financial incentives which musculoskeletal commissioners might wish to adopt to incentivise high quality care

Whilst the development of NICE clinical guidelines on musculoskeletal conditions such as rheumatoid arthritis, osteoarthritis and osteoporosis has gone some way to address this the implementation of these guidelines remains highly variable.

New NICE quality standards provide an opportunity to assist commissioners in developing effective, high quality musculoskeletal services.

ARMA welcomed the inclusion of five key musculoskeletal conditions in the draft list of quality standards to be developed by NICE (see box below):

Proposed quality standards to be developed for musculoskeletal conditions

- Osteoarthritis
- Rheumatoid arthritis
- Low back pain
- Seronegative arthropathies
- Elective joint replacement (hip, knee and shoulder)[clxii]

In addition, the new commissioning outcomes framework, will provide an important tool to measure the performance of commissioners in commissioning musculoskeletal services. In order to drive improvements in musculoskeletal commissioning the commissioning outcomes framework should include metrics and mechanisms within it relating to delivering high quality services for musculoskeletal patients.

It is also important to ensure that providers are appropriately incentivised to deliver improvements in the quality of musculoskeletal services. This can be achieved through the introduction of Commissioning for Quality and Innovation (CQUIN) schemes and the inclusion of appropriate indicators within the Quality and Outcomes Framework.

The development of a musculoskeletal programme-level outcomes strategy would bring cohesion to the introduction of new levers within the system. It would ensure that services for patients with musculoskeletal conditions are prioritised and it would stimulate a step-change in the way that services are delivered. A national outcomes strategy would:

- Set out the ambitions for improving outcomes in musculoskeletal conditions
- Make clear the support, information and choices which patients and service users, and their carers and families, will receive to make best use of these high-quality services
- Describe the ways in which these services will be held to account for the outcomes they deliver through the NHS, social care and public health outcomes frameworks
- Confirm the support which the Government will provide to assist these services meet the outcomes for which they are accountable
- Articulate how the Government will lead work with non-state sectors to help shape services that meet the needs of patients and service users

Outcomes strategies have already been developed for conditions such as cancer, mental health and chronic obstructive pulmonary disease (COPD) and given the prevalence and cost of musculoskeletal conditions in England, a strategy should be developed which would help address variations in service provision, ensure that money on musculoskeletal conditions is being spent appropriately and send a clear signal that musculoskeletal conditions must be seen as a priority.

The purpose of calling for a strategy is not to spend more money on musculoskeletal conditions or set out top down directives, but to ensure that limited resources across the main areas of healthcare delivery are used to best effect to ensure that services genuinely meet the needs of people with musculoskeletal conditions. In most cases, changing a few simple things in everyday practice, such as embedding self-management in routine care for people with all forms of arthritis, and a greater focus on prevention and early intervention, could make a vast difference to patient outcomes.

Such a strategy would support moves towards integration, personalised care, 'whole person' approach, and supporting people with long-term conditions to self-manage and remain independent. Musculoskeletal conditions not only affect a large number of patients, but they command a significant proportion of NHS expenditure, and are associated with a number of co-morbidities. Yet without clear and robust guidelines and indicators and without clear direction or prioritisation from the National Commissioning Board, people with musculoskeletal conditions could miss out on the promise of higher quality services. A strategy would ensure that the current goals and direction of travel of the NHS translate into real, concrete outcomes for the many millions of people with a musculoskeletal condition in England today.

Recommendation 24: the Department of Health should engage with new clinical commissioning groups prioritising musculoskeletal conditions to identify areas of good practice commissioning of musculoskeletal services

Recommendation 25: the commissioning outcomes framework should contain measures and metrics to ensure that the quality of care for musculoskeletal conditions improves

Recommendation 26: the NHS commissioning board should develop CQUINs for musculoskeletal conditions to incentivise providers to improve the quality of services

Recommendation 27: the Department of Health should develop a national outcomes strategy for musculoskeletal conditions

Recommendation 28: good practice commissioning guidance should be developed as a priority and be consistent with quality standards developed by NICE

Involving service users

It is critical that people with musculoskeletal services are partners in both the planning and delivery of their care. There should be opportunities for patients to engage with the commissioning process through the appropriate channels. In addition patients should be well supported to take part in the decision making process about their care. This is about much more than just choice of provider, but also choice of treatment, healthcare professional and place of care. Service providers should draw on the expertise of the voluntary sector to improve their ability to challenge the traditional relationship between patient and clinician and engender a shared dialogue around care.

Recommendation 29: health and wellbeing boards, Healthwatch and patient groups should play a facilitating role for public and patient involvement in the commissioning of musculoskeletal services. New health and wellbeing board learning networks should play an important role in this

Recommendation 30: commissioners and providers should ensure that patients can make informed choices about their care, making full use of decision aids, information prescriptions and voluntary sector advice

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Chapter 9: conclusion

Musculoskeletal conditions have been under-prioritised within the NHS for too long. Whilst well intentioned the publication of the MSF has made a limit impact on service provision, variations in care have become more pronounced in the two years since the first audit was conducted, and there is a pressing need to deliver much better outcomes for patients living with these chronic and debilitating – but often manageable conditions.

ARMA's updated audit of the state of musculoskeletal services unfortunately demonstrates that little progress has been made since the previous audit in 2009. Whilst there have been improvements in some areas, in the majority progress has stalled or been put into reverse. Given the rising costs associated with these conditions and increasing rates of prevalence, musculoskeletal conditions represent an urgent priority for NHS organisations.

ARMA plans to continue to raise awareness of the need to prioritise musculoskeletal conditions following this research. Further research is also needed to ascertain the level of understanding amongst existing and new commissioners of musculoskeletal conditions as well as the ways in which new commissioners intend to prioritise the improvement of these services.

The changing NHS structures present clear opportunities to improve services for musculoskeletal conditions. To deliver the progress required, musculoskeletal conditions will need to be prioritised in a way that they have not been in the past. The significant impact of musculoskeletal conditions across public health, NHS and social care means that the best way to ensure that musculoskeletal conditions are prioritised is through the developments of a national strategy for musculoskeletal conditions. ARMA looks forward to working in partnership with government and the NHS to develop and implement the necessary policy levers, and realise the potential of the NHS reforms to benefit musculoskeletal patients wherever they live.

Annex 1: developing quality metrics in NHS musculoskeletal services

A discussion document – May 2010

Summary

This note sets out key points raised during a discussion between clinicians, commissioners and patients with an interest in musculoskeletal care on how best to measure quality in musculoskeletal conditions.

Discussion of outcome measures coalesced around two broad categories of outcome measure:

Patient-reported outcome measures (PROMs) –outcomes which patients themselves are asked to report on. These measures are hereafter referred to as PROMs. PROMs either:

- Measure a patient’s health status; or
- Measure a patient’s quality of life (hereafter referred to as quality of life measures – see box, below)

Service-level outcome measures (SLOMs) – a term used by the group to refer to those objective measures of service performance for which patient input was not required. These SLOMs can be subdivided into:

- ‘Structure indicators’, which describe organisational aspects of care (such as, for example, the adequacy of facilities)
- ‘Result indicators’, which describe results set against the final goals of delivered care

The group agreed that the criteria against which the effectiveness of any outcome measure should be tested are:

I. Amenability to intervention (ie will the outcome measures change in the event of a positive or negative change)
II. Sensitivity to intervention (ie will the outcome change significantly enough and fast enough such that it is worth the providers’ / commissioners’ effort in making a positive change)

Within these two broad categories, the group identified four different domains of outcome indicator as follows:

- Outcomes which measure the effectiveness of preventative care
- Outcomes which measure the effectiveness of care delivered for long-term conditions
- Outcomes which measure the effectiveness of care delivered for episodic conditions
- Outcomes which measure the effectiveness of acute single episodes of care

Outcome measures can therefore fit into the following matrix:

	Preventative	Acute, single	Episodic	Long-term
SLOMs	*a* *b* *c*	x	x	x
PROMs	x	x	X	x

Examples of such metrics are included below.

- **Outcomes which measure the effectiveness of preventative care**

  These outcome measures might include:
  SLOMs

  - Reductions in recurrent osteoporotic fractures
  - Reductions in osteoporotic fracture risk (by using tools such as FRAX)
  - Waiting time for a patient with a musculoskeletal condition between first attendance at a GP practice and first referral to a specialist
  - Waiting time for a patient with rheumatoid arthritis between first symptomatic presentation at a GP practice and diagnosis with disease-modifying anti-rheumatoid drugs (DMARDs)

  PROMs
  - Limitation of self-reported occurrence of musculoskeletal pain

- **Outcomes which measure the effectiveness of acute single episodes of care**

  These outcome measures might include:

  SLOMs

  - Emergency readmission within 28 days of discharge
  - Percentage of patients returning to pre-admission domicile
  - Length of stay
  - Re-operation rates
  - Surgical complication rates

  PROMs

  - Percentage of patients self-reporting changes in pain and mobility after episode
  - Percentage of patients self-reporting a return to function

- **Outcomes which measure the effectiveness of care delivered for episodic conditions**

  These outcome measures might include:
  SLOMs

- Percentage of patients returning to work within *n* days of episode beginning (where research is required to define *n*)
- Number of days off work amongst patients with musculoskeletal conditions in contact with health services over a given time period
- Incapacity benefits claimed per head of person with a musculoskeletal disorder over a given time period

PROMs

- Percentage of patients self-reporting that they have returned to 'normality' (such a measure may include any or all of a self-reported return to work, a self-reported absence of pain, or a self-reported return

- **Outcomes which measure the effectiveness of care delivered for long-term conditions**

The group noted that there is a substantial overlap between 'long-term conditions' and 'episodic' conditions – particularly in relation to musculoskeletal disorders. For example, inflammatory arthritis and osteoporosis are both conditions which are long-term in nature (ie they have no 'cure') but nevertheless will tend to present to the health services only in an episodic manner (eg during a 'flare up' or a fracture respectively). Conversely, osteoarthritis (a condition distinct from rheumatoid arthritis) tends to be a long-term condition, which needs to be managed on a consistent basis by the health services rather than on an episodic basis.

These outcome measures might include:
SLOMs

- Percentage of patients returning to work within *n* days of episode beginning (where research is required to define *n*)
- Number of days off work amongst patients with musculoskeletal conditions in contact with health services over a given time period
- Incapacity benefits claimed per head of person with a musculoskeletal disorder over a given time period

Hybrid

- Disease-activity score

PROMs

- Percentage of patients self-reporting that they have returned to 'normality' (such a measure may include any or all of a self-reported return to work, a self-reported absence of pain, or a self-reported return

Annex 2: PCTs which responded to the audit

The following PCTs responded to our audit, we are grateful to them for doing so:

Ashton, Leigh and Wigan PCT
Barnet PCT
Barnsley PCT
Bassetlaw PCT
Bedfordshire PCT
Berkshire West PCT
Bexley Care Trust
Blackburn with Darwen PCT
Bolton PCT
Bournemouth and Poole PCT
Bradford and Airedale Teaching PCT
Brighton and Hove PCT
Bristol PCT
Bromley PCT
Bury PCT
Calderdale PCT
Central Lancashire PCT
City and Hackney Teaching PCT
County Durham PCT
Coventry PCT
Croydon PCT
Derby City PCT
Derbyshire County PCT
Doncaster PCT
Ealing PCT
East Lancashire PCT
East Riding of Yorkshire PCT
East Sussex Downs and Weald PCT
Eastern and Coastal Kent PCT
Gateshead PCT
Gloucestershire PCT
Great Yarmouth and Waveney PCT
Halton and St Helens PCT
Hartlepool PCT
Hastings and Rother PCT
Heart of Birmingham PCT
Heywood, Middleton and Rochdale PCT
Kingston PCT
Kirklees PCT
Knowsley PCT
Lambeth PCT
Leeds PCT
Leicestershire County and Rutland PCT
Lewisham PCT
Lincolnshire PCT

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Luton PCT
Medway PCT
Mid Essex PCT
Middlesbrough PCT
Milton Keynes PCT
Newcastle PCT
Newham PCT
North East Essex PCT
North East Lincolnshire PCT
North Lancashire PCT
North Lincolnshire PCT
North Somerset PCT
North Tyneside PCT
North Yorkshire and York PCT
Northumberland Care Trust
Nottingham City PCT
Nottinghamshire County PCT
Oldham PCT
Oxfordshire PCT
Peterborough PCT
Plymouth PCT
Portsmouth City PCT
Redcar and Cleveland PCT
Richmond and Twickenham PCT
Sandwell PCT
Sefton PCT
Sheffield PCT
Somerset PCT
South Birmingham PCT
South Gloucestershire PCT
South Staffordshire PCT
South Tyneside PCT
South West Essex PCT
Southampton City PCT
Stockport PCT
Stockton on Tees PCT
Stoke-on-Trent PCT
Suffolk PCT
Sunderland PCT
Surrey PCT
Sutton and Merton PCT
Swindon PCT
Tameside and Glossop PCT
Telford and Wrekin PCT
Torbay Care Trust
Tower Hamlets PCT
Trafford PCT
Walsall Teaching PCT
Wandsworth PCT

Warrington PCT
West Essex PCT
West Hertfordshire PCT
West Kent PCT
West Sussex PCT
Western Cheshire PCT
Wiltshire PCT
Wolverhampton City PCT
Worcestershire PCT

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Annex 3: Freedom of Information requests

Freedom of Information Officer
XX PCT
Address

DATE

Dear Sir/Madam

Freedom of Information Act requests

I wish to make a series of separate requests under the Freedom of Information Act. For convenience, I am including them in the same email. Please:

#1 *Please confirm or deny that your Primary Care Trust (PCT) operates a clinical assessment and treatment service (CATS) for musculoskeletal services.*

If confirmed:

- ***#1a*** *Please state whether it is located in primary or acute care.*
- ***#1b*** *Please list the job titles of its staff*
- ***#1c*** *Please confirm or deny if it is fully integrated with the local pain management service*
- ***#1d*** *Please supply any agreed referral processes for musculoskeletal conditions*

#2 *Please confirm or deny that your PCT operates an integrated falls service with your local authority*

#3 *Please confirm or deny that your PCT includes musculoskeletal conditions within its definition of long-term conditions*

#4 *Please supply a list of all the specific conditions which are included in your PCT's list of long-term conditions.*

#5 *Please state the total number of patients (a) with long-term conditions and (b) with musculoskeletal conditions in your PCT area.*

#6 *Please confirm or deny that your PCT has developed a framework for continuous improvement in musculoskeletal services.*

#7 *Please confirm or deny that your PCT has conducted an audit of the outcomes of patients with musculoskeletal conditions.*

#8 *Please list the outcome indicators you use to conduct the audit of the outcomes of patients with musculoskeletal conditions.*

#9 *Please list your overall expenditure on problems of the musculoskeletal system in each of the last three financial years, broken down by expenditure on each specific musculoskeletal condition.*

#10 *Please confirm or deny that your PCT has mapped current resources for people with long-term conditions and their use.*

#10a *If confirmed, please supply details of the audit.*

#11 *Please confirm or deny that your PCT works with voluntary and community organisations to support patients with musculoskeletal problems.*

#11a *If confirmed, please list the groups with which your PCT works.*

#12 *Please confirm or deny that your PCT provides information to patients on musculoskeletal conditions to support self-care.*

#12a *If confirmed, please supply this information.*

#13 *Please confirm or deny that your PCT has made links with your local Pathways to Work scheme.*

#14 *Please confirm or deny that your PCT has identified clinical champions for musculoskeletal services.*

#15 *Please list the total number of rheumatologists in your PCT area in each of the last three years.*

#16 *Please confirm or deny that your PCT provides education for GPs about how to manage patients with suspected rheumatoid arthritis.*

#16a *If confirmed, please supply details.*

#17 *Please confirm or deny that your PCT has made an assessment of the (i) capacity and (ii) cost of intravenous services for people living with inflammatory arthritis in (a) hospital and (b) community settings in your PCT area.*

#17a *If confirmed, please supply details.*

#18 *Please confirm or deny that your PCT has made an assessment of the average waiting time for a follow-up appointment for a patient with rheumatoid arthritis.*

#18a *If confirmed, please supply details.*

#19 *Please confirm or deny that your PCT has had any communication with the Department of Health on the Atlas of Variations.*
#19a *If confirmed, please supply details of the communication*
#19b *If confirmed, please also supply details of the action your PCT is taking as a result of the communication.*

#20 *Please confirm or deny that your PCT has reviewed or is planning to review expenditure on musculoskeletal services following the publication of the Atlas of Variations.*
#20a *If confirmed, please supply details.*

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#21 *Please confirm or deny that your PCT has had communication with the Department of Health on implementing the musculoskeletal service framework.*

#21a *If confirmed, please supply details of the communication.*

#21b *If confirmed, please also supply details of the action your PCT is taking as a result of the communication.*

#22 *Please confirm or deny that your PCT has had communication with your SHA on implementing the musculoskeletal service framework.*

#22a *If confirmed, please supply details of the communication.*

#22b *If confirmed, please also supply details of the action your PCT is taking as a result of the communication.*

#23 *Please confirm or deny that your PCT has been in communication with GP pathfinder consortia.*

#23a *If confirmed, please supply details of the communication.*

#24 *Please confirm or deny that your PCT has been in communication with GP pathfinder consortia about musculoskeletal services.*

 # 24a *If confirmed, please supply details of the communication.*

#25 *Please confirm or deny that your PCT uses programme budgeting data to define resource allocation to improve services?*

#25a *If confirmed, please supply details in relation to allocations affecting musculoskeletal services*

 # 26 *Please confirm or deny that your PCT Board has had any discussions about unwarranted variations in the provision of musculoskeletal conditions in comparison with other PCTs?*

#26a *If confirmed, please supply minutes of the discussions*

Annex 4: about the Arthritis and Musculoskeletal Alliance

The Arthritis and Musculoskeletal Alliance (ARMA) is the umbrella body providing a collective voice for the arthritis and musculoskeletal community in the UK. ARMA is the umbrella organisation for the UK musculoskeletal community. ARMA is a registered charity No 1108851. Together, ARMA and its member organisations work to improve the quality of life for the 12 million people in the UK who live with a musculoskeletal disorder.

ARMA has 35 member organisations representing a broad range of interests across service user, professional and research groups working in the field of musculoskeletal disorders. Our member organisations are:

Arthritis Care
Arthritis Research UK
BackCare
Birmingham Arthritis Resource Centre
British Chiropractic Association
British Health Professionals in Rheumatology
British Institute of Musculoskeletal Medicine (BIMM)
British Orthopaedic Association
British Osteopathic Association
British Sjogren's Syndrome Association (BSSA)
British Society for Paediatric and Adolescent Rheumatology (BSPAR)
British Society for Rheumatology (BSR)
British Society of Rehabilitation Medicine
Chartered Society of Physiotherapy
COT Specialist Section - Rheumatology
Early Rheumatoid Arthritis Network (ERAN)
Fibro Action
Fibromyalgia Association
Lupus UK
MACP
McTimoney Chiropractic Association
National Ankylosing Spondylitis Society (NASS)
National Association for the Relief of Paget's Disease
National Rheumatoid Arthritis Society (NRAS)
PMR GCA – UK
PMR GCA - Scotland
Podiatry Rheumatic Care Association
Primary Care Rheumatology Society
Psoriasis Association
Psoriasis Scotland Arthritis Link Volunteers
Rheumatoid Arthritis Surgical Society
Royal College of Nursing Rheumatology Forum
RSI Action
Scleroderma Society
Scottish Network for Arthritis in Children

ARMA has a unique approach, bringing its members together to work collaboratively towards common goals and instigate joint initiatives. ARMA does this through a variety of projects and activities.

As an umbrella body, ARMA works with its members to achieve consensus in its campaign and policy work. ARMA has a strong track record of user involvement in all its activities and structures.

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