

Expert Opinions in Rheumatology

Issue 2

The PCR Society
Guide to Commissioning
Musculoskeletal Services



September 2011

Acknowledgements

This guide is the result of a joint initiative between the Primary Care Rheumatology (PCR) Society, the Arthritis and Musculoskeletal Alliance (ARMA), the British Society for Rheumatology (BSR) and the British Orthopaedic Association (BOA).

The PCR Society would like to thank the following for their valuable contributions to this publication, at a two day meeting in York (4-5 March, 2011), to address the commissioning issues associated with development of MSK services, and/or in commenting on a series of drafts of this final guidance:

Professor David Colin-Thome, Professor David Blake, Ms Ailsa Bosworth, Mr Philip DaSilva, Dr Chris Deighton, Dr Alastair Dickson, Dr John Dickson, Ms Helen Duffy, Mr Denis Gizzi, Mr Jamie Hewitt, Dr Andrea Jones, Mr Peter Kay, Dr Peter Lanyon, Ms Jacqui Lyttle, Dr Tom Margham, Ms Ros Meek, Dr Arthur Mone, Mr Tony Murray, Dr Alan Nye, Mr Mike Palmer, Dr Mark Porcheret, Mr Ian Reeve, Ms Jenny Snell, Dr Louise Warburton, Dr Elspeth Wise

Editorial support was provided by Jenny Bryan.

This publication has been produced with support from MSD, AstraZeneca and Pfizer. These companies have had the opportunity to review the publication for factual accuracy and balance, but ultimate editorial control rested with the PCR Society.

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Preface

The introduction of primary care commissioning of musculoskeletal (MSK) services is a much-needed opportunity to redesign an outdated, hospital-oriented system of care. This system was set up long before advances in physiotherapy, exercise and drug interventions resulted in opportunities for community-based services to achieve better outcomes and enable more efficient use of resources.

The NHS now spends over £4 billion per year on MSK services, making MSK disorders the fifth highest area of NHS spending¹ (*Figure 1*). How we redesign and commission MSK services today will direct provision across the country for at least the next 20 years. It is therefore essential that we develop a patient-centred, integrated system which addresses the full range of public health, NHS and social care needs associated with MSK disorders. However, the system must also be sufficiently flexible to enable clinical commissioning groups to adapt their services to local situations and requirements.

Figure 1: The burden of MSK disorders²

- About 1 in 4 adults are affected by longstanding MSK problems
- MSK conditions are responsible for up to 30% of GP consultations
- MSK disorders are the most common reason for repeat consultations with GPs
- Up to 60% of people who are on long-term sick leave cite musculoskeletal problems as the reason
- 40% of people over 70 have osteoarthritis of the knee
- An estimated 8–10 million people in the UK have arthritis, including 1 million adults under the age of 45, upwards of 12,000 children and 70% of 70-year-olds
- Upwards of 400,000 adults in the UK have rheumatoid arthritis, about 200,000 have been diagnosed with ankylosing spondylitis, and as many as 177,000 have psoriatic arthritis
- Low back pain is reported by about 80% of people at some time in their life
- Over 3.5 million calls per year to emergency services relate to MSK injuries or conditions
- Over 1 in 5 people with MSK disorders receive incapacity benefits

This Guide has been written by the Primary Care Rheumatology (PCR) Society for its members and others who are involved in commissioning MSK services. Its recommendations are based on the expert opinion of those attending a two day meeting, held earlier this year, to address the commissioning issues associated with the development of MSK services. It is part of an ongoing initiative with the Arthritis and Musculoskeletal Alliance (ARMA), the British Society for Rheumatology (BSR) and the British Orthopaedic Association (BOA).

The guide uses the most relevant of the rapidly growing array of electronic information, templates and tools being developed by the Department of Health (DH) and

professional organisations to support implementation of the reforms proposed in Equity and excellence: Liberating the NHS³ and revised in response to recommendations from the NHS Future Forum⁴ (Figure 2). Just as importantly, it draws on the knowledge and insights of healthcare professionals and commissioners with first hand experience of developing and providing MSK services for the modern era.

Figure 2: The new NHS – expected changes^{5,6,7}

- Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) abolished
- NHS Commissioning Board set up as an independent statutory body to commission primary care services, national and specialised regional services, authorise clinical commissioning groups, provide national leadership for driving up quality of care, and actively promote the NHS Constitution
- Health and Wellbeing Boards established in local authorities to lead strategic coordination of commissioning across the NHS, social care, related children's and public health services.
- Clinical commission groups to take over commissioning role from PCTs. With at least one nurse, one specialist doctor and lay members on their governing bodies, they will be supported by clinical networks (advising on single areas of care) and "clinical senates" in each area of the country (providing multi-professional advice on local commissioning plans) – both hosted by the NHS Commissioning Board.
- Public Health England and local councils to assume public health responsibilities from SHAs and PCTs
- Care Quality Commission (CQC) to register all healthcare providers and host HealthWatch England which will act as consumer champion and lead local HealthWatch organisations (evolving from Local Involvement Networks [LINKs])
- Monitor to protect the interests of patients, by promoting value for money and quality in the provision of services
- National Institute for Health and Clinical Excellence (NICE) to set out quality standards to underpin outcome goals

In such a fast-moving arena, we do not claim that this Guide is comprehensive or has all the answers for would-be commissioners of MSK services. But it does:

- Address key commissioning issues identified by early adopters/pathfinders of integrated MSK programmes
- Stress the importance of breaking down barriers between primary care and hospital services, and keeping healthcare professionals in both groups fully informed about developments in local commissioning of MSK services
- Provide examples of primary care based MSK services which already work well
- Signpost to web-based and other sources of more detailed information

The Guide forms part of a broader PCR/ARMA commissioning initiative which will continue to evolve during 2011-2014 and beyond.

What makes good commissioning?

Summary

- Commissioning of MSK services should be patient focused and outcomes driven, with widespread stakeholder consultation and involvement from the outset
- Potential conflicts between GPs as commissioners and GPs as providers are not insurmountable but must be addressed
- A complete review of current local MSK needs and healthcare provision by all NHS and independent providers should identify services which work/are failing, need expansion/replacement, and should include full costings and assessment of ability to meet required outcomes. Results should be compared with similar populations in other areas
- Clinical, patient-reported, and service level outcomes should be identified for the new MSK service, with reference to domains of the NHS Outcomes Framework and NICE guidelines on rheumatoid arthritis, osteoarthritis and low back pain
- Specific MSK services can be commissioned from any qualified providers (AQPs), or clinical commissioning groups can work with prime vendors to develop integrated care pathways for some/all of local MSK services
- Redesign is only part of the commissioning role. Commissioners should also support providers in developing additional capacity and capabilities, as removal of a pivotal MSK service from a current provider can have major consequences for their continuing ability to provide other MSK and non-MSK services
- Shared decision making can help to reduce unwarranted variation
- Services do not necessarily have to go to tender, but potential providers must be able to demonstrate their expertise and ability to deliver to required timescales
- Commissioners should be aware of anti-competition regulations and consider taking legal advice over the need for medical indemnity to cover commissioning activities and any possible legal challenges that may result from commissioning decisions
- Quality incentives, both financial (eg: Commissioning for Quality and Innovation (CQUIN) indicators [CQUINs]) and non-financial, have a key role in assisting effective commissioning.

The role of Clinical Commissioning Groups

The Department of Health outlined the general functions of commissioning groups in a working document, published in March 2011⁸. Although the name and nature of these groups have been revised following publication of the NHS Future Forum report, the overarching role remains to plan, agree and monitor services, improve the quality of primary care and ensure that commissioning budgets are not exceeded. Commissioning groups should be transparent about decision making (governance), adopt an evidence based approach to assessing needs, designing services and monitoring outcomes, and should work in cooperation with other relevant organisations.

Developing an MSK service specification can appear a daunting prospect. But there is no need to start with a blank piece of paper. In addition to the MSK service specification(s) used previously by your PCT, a large number of specifications are freely available on the internet, though not yet in a central electronic library. For example, NHS Supply2Health is an online resource that advertises opportunities to provide clinical services commissioned by the NHS in England, and gives details of contracts that have been awarded: <http://www.supply2health.nhs.uk/default.aspx>

Who should commission MSK services?

Stakeholder engagement is essential, and the commissioning group for MSK services should include representatives of all who will be affected by commissioning decisions. This will encourage practices to take ownership of the service specification and follow provider pathways, increasing the likelihood of required outcomes being achieved. In some areas, large public consultations are creating great interest, attracting innovative ideas and valuable contributions to the development of local healthcare services.

Within the commissioning group for MSK services, an initial core group is likely to be led by the MSK Clinical Programme Director, with support from a senior professional manager, such as the Executive Director of Commissioning and Service Reform, and include local GPs, secondary care consultants, and relevant representatives of other professional and patient groups. As the service specification develops, input will be needed from a wider group of allied public health and healthcare professionals, patients, social care, financial and other relevant managers.

Clinicians and other healthcare professionals with the specialist knowledge required to advise about an MSK service specification may also want to be considered as service providers. This potential conflict of interest is not an insurmountable problem, and the DoH is likely to provide guidance. Conflicting roles need to be addressed openly and honestly, and mechanisms put in place to ensure transparency and good governance. In this way, local expertise can be put to best use for both commissioning and provision of MSK services.

While clinicians in a commissioning group need to become familiar with the broad concepts of developing a service specification, issuing invitations to tender, and assessing provider applications, upskilling in the more detailed aspects of contract negotiation and procurement is wasteful. Detailed management of the commissioning process can be undertaken either by "in-house" managers with appropriate expertise or by outsourcing to independent commissioning consultants, depending on which approach makes best use of local resources.

Reviewing current services

A full healthcare market analysis of current service provision, by all NHS and independent providers, is an essential starting point for any commissioning group for MSK services. This analysis needs to consider every aspect of the MSK pathway and identify MSK services which work or are failing, need expansion or replacement, and should include full costings and assessment of how well services are achieving their required outcomes. Breaking services down into manageable segments facilitates this process and yields meaningful data.

“Barn door” questions which need to be answered are:

- Can patients get access to the MSK care they need?
- Does this happen within an acceptable timescale across all parts of the pathway?
- Is this achieved with sufficient control of costs?
- Can a redesign realistically achieve improvement (eg: reduce unwarranted variation)?

Additional questions are:

- Is the health status of patients being improved?
- Is the Provider delivering a safe and effective service
- At an individual level, is the patient experience of MSK care improving?
- Is the per capita cost of the MSK condition being treated within cost control limits?

Surveying local patients and seeking the opinions of stakeholders, such as GPs, can provide useful insights. Taking the time to carry out such a review and produce a full report will not only help to inform subsequent commissioning decisions, it will provide an important point of reference if there is a later need to explain or clarify the group’s eventual choice of service provider.

No future service can be planned without accurate information about local epidemiology, such as population size, incidence and prevalence of MSK disorders, current treatment needs and numbers of healthcare professionals providing current services (*Figure 3*). For this baseline audit, current levels of care can be compared with recommended standards, such as those produced by NICE and ARMA.

The information gathered in this initial review can be used to compare local disease rates and treatment provision with that of comparable populations in other areas, so that anomalies can be identified and addressed in the new MSK specification. It is important always to compare like with like. There may be good reasons why a system which works in one part of the country doesn’t work well in another. City versus rural environment and variations in patient demographics and socioeconomics all play a role.

Figure 3: Useful data sources for review of MSK services

- Public Health Observatories: data include small area indicators, such as population estimates, mortality, hospitalisation, lifestyle and socio-economic data, for use in needs assessments; health inequalities data; health profile data including physical activity levels (adults), hip fracture in over-65s, by small geographical area.
Access at: <http://www.apho.org.uk/default.aspx>
- NHS comparators: holds secondary care activity data, GP list size data (population data), Quality and Outcome Framework data, prescribing data.
Access at: <http://www.ic.nhs.uk/nhscomparators>
- Programme budgeting: includes commissioner level programme budgeting data as benchmarking tool that enables commissioners to identify how they spend their allocation over the 23 diseases and their respective subcategories; how, and by how much, their expenditure distribution pattern compares with other commissioners nationally, locally or with similar characteristics and how their expenditure distribution has changed over time.
Access at: <http://www.dh.gov.uk/en/Managingyourorganisation>
- Hospital Episode Statistics (HES): inpatient and outpatient data for England, at national and local provider levels. Experimental data on PROMS include hip and knee replacement reporting at national, commissioner and provider levels.
Access at: <http://www.hesonline.nhs.uk>
- Quality and Outcomes Framework (QOF) data: practice data on achievement of clinical, patient experience, organisation and additional service outcomes. Although there are currently no QOF targets for MSK, a new target for osteoporosis is expected in 2012/2013.
Access at: <http://www.qof.ic.nhs.uk/>
- Prescribing Support Unit: manages a national prescribing information database, the Prescription Cost Analysis (PCA), which is used for analysing and monitoring the use of medicines in primary care.
Access at: <http://www.ic.nhs.uk/services/prescribing-support-unit-psu>
- Uptake of Medicines: experimental data on use of NICE-appraised medicines in the NHS.
Access at: <http://www.ic.nhs.uk/pubs/niceappmed0910>
- ARMA musculoskeletal map: shows local variations in quality of MSK services in England (2008-2009).
Access at: <http://www.arma.uk.net/current.html#MuskuloMap>
- The NHS Atlas of Variation in Healthcare: includes maps of variation for MSK expenditure, pre-operative EQ-5D score for knee replacement, provision of hip replacement and expenditure on anterior cruciate ligament reconstruction.
Access at www.rightcare.nhs.uk

Room for improvement?

Having established the size and nature of your MSK population and the way it is currently managed, the next stage is to use simple comparisons of MSK Programme Budgets (as provided within the Atlas of Variation) to begin to identify relative opportunities for redesign and/or fundamental local market re-shaping.

As a general rule, an MSK programme budget which falls within the bottom quartile, ie: it has a high spend for relatively poorer outcomes, should be considered for redesign. A budget which falls closer to the national average or above may need adjustment rather than redesign

To dig deeper into the way clinical pathways are followed locally, it may be useful to audit aspects of care which appear to be sub-optimal (*Figure 4*) and to consider potential sources of waste (*Figure 5*). For example, if the number of outpatient appointments for MSK disorders appears high, compared with national data, a sample of referrals during a period of time can be analysed by local clinicians to get a better understanding of how and why patients were being referred and whether this pattern – and associated outcomes – could be improved by changes in service provision.

Figure 4: Aspects of MSK services which may need to be examined

- Access into community-based and specialist services, ie: availability, referral times and waiting times
- Access to multidisciplinary teams (MDTs)
- Accessibility of specialist care (eg: convenience for patients [transport, free parking, disabled access])
- Unscheduled case levels
- First follow-up rates
- Conversion to surgery rates
- Unnecessary follow-ups
- Bed days of care
- Medicines management
- Flares service
- Readmission rates
- Implementation of national guidelines, eg: NICE
- Ability to meet identified needs (eg: patient experience and outcomes)
- Impact on return to work/liaison with occupational health
- Staff training and education
- MSK audit and governance systems
- Cost controls

Figure 5: Main Sources of Waste

- Unwarranted variation in systems
- Excessive administration and buildings
- Unnecessary processes and treatments of limited value
- Inappropriate use of skills
- Not getting the right patient to the right clinician, first time.
- Duplication of activity across different organisations and tiers of healthcare, as a result of poor communication of information or lack of understanding of respective roles, or both.

Which outcomes?

Commissioning groups are encouraged to use an outcomes-driven approach to commissioning which aims to get away from centrally-driven process targets, and deliver outcomes that matter most to patients^{3,5}. To this end, the NHS Outcomes Framework sets national outcome goals, across 5 domains (Figure 6)⁸.

Figure 6: Domains of the NHS Outcomes Framework

| | | |
|----------|--|----------------------|
| Domain 1 | Preventing people from dying prematurely | } Effectiveness |
| Domain 2 | Enhancing quality of life for people with long-term conditions | |
| Domain 3 | Helping people to recover from episodes of ill health or following injury | |
| Domain 4 | Ensuring that people have a positive experience of care | } Patient experience |
| Domain 5 | Treating and caring for people in a safe environment and protecting them from avoidable harm | } Safety |

In its response to the NHS Future Forum report, the government underlined its continuing commitment to the 18 week waiting limit from GP referral to the start of a patient's first definitive treatment (18wRTT). Whilst the monitoring mechanism for the 18wRTT has shifted to measuring the mean rates for RTT times, it is still important to embed the principle of individual RTT guarantees for MSK services at a local level.

There is a large and growing literature on outcomes – generic and disease-specific, patient-reported outcome and experience measures (PROMS and PREMs) and service level outcome measures (SLOMS). It would be unwise to make hard and fast recommendations, but MSK outcomes should be aligned with the 5 domains of the new NHS Outcomes Framework (Figure 6)⁸.

Across the domains there are 10 overarching indicators for tracking progress at a macro level, 31 improvement areas which the National Commissioning Board will be required to deliver and 51 indicators in general. Over the next 5 years, it is planned that NICE will develop 150 Quality Standards, and these evidence-based recommendations will underpin outcomes assessments. Indicators and Quality Standards relevant to MSK services are summarised in *Appendix 1*.

With so many potential outcome measures to choose from, there is a risk of introducing such a large number that the process of monitoring becomes costly and confusing. Private-sector specialist outsourcing companies working in areas outside healthcare have suggested a maximum of 10 outcomes should be measured for optimal cost-effectiveness.

Whatever outcomes are chosen, the number of outcomes to be measured, and the method by which this data will be captured, needs to be agreed with service providers, to ensure absolute clarity about the definitions being utilised and measures to be monitored.

Any outcome measure chosen to assess the value of MSK services should have two key properties:

- Amenability to intervention (ie: it will show a positive or negative change in response to intervention)
- Sensitivity to intervention (ie: it will change significantly enough and fast enough to demonstrate the effects of change within a reasonable timeframe, usually two to three years)

Outcome groups which are relevant to MSK are those which measure the effectiveness of care delivered for:

- Prevention
- Acute single episodes
- Episodic conditions
- Long term conditions

Potential outcomes suitable for measurement are summarised in *Appendix 2*. In the current absence of Quality and Outcomes Framework (QOF) indicators or a National Service Framework for MSK disorders, key priorities for implementation of NICE guidelines on rheumatoid arthritis, osteoarthritis, low back pain may be useful in generating good MSK outcomes for commissioners^{9,10,11} (*Appendix 3*).

A number of patient reported indicators are available which have been validated for clinical trials, eg: EQ-5D. Further PROMS/PREMS are in development which may be more relevant to everyday clinical care, but will also require validation.

Outcomes need to have realistic timescales, and should include a mixture of small interventions which are likely to yield rapid benefits, and larger interventions with longer term potential benefits.

It is essential to make baseline measurements against which outcomes can be compared, and to establish the role of senior clinicians, Health and Wellbeing Boards and any other appropriate regulators in monitoring outcomes.

Comparing outcomes achieved by potential providers can be challenging, unless data are

available from comparable time periods. It may be more appropriate to measure changes in outcomes achieved by a potential provider against their own baseline to see where improvements were achieved, eg: hip/knee replacement: pre-op, post-op, reassess 2/3 times per year.

Commissioning options

Current DH guidance outlines three options for local commissioning¹²:

- 'Any Qualified Provider' (AQP) which enables any provider registered with the CQC to bid to provide specific services, with the aim of extending patient choice
- Contract management which enables commissioners to secure incremental improvements/changes to existing service contracts, or to address underperformance as an alternative to procurement (eg: to reduce cost)
- Procurement options which enable commissioners to develop services outside the scope of existing contracts (eg: new models/increased capacity), or when existing contracts are due to expire or need to be terminated (eg: when contract management cannot address underperformance).

Any Qualified Provider or Prime Vendor?

The AQP approach to MSK service provision is quicker and less bureaucratic than traditional procurement, and avoids the cost and time involved in undertaking a competitive tender. Although concerns have been raised about the AQP model, AQPs will have to meet the same safety and quality standards as larger service providers, in order to be registered with the CQC.

It is expected that AQPs will include GPs and other healthcare professionals (HCPs). AQPs who are commissioned to provide local services will have no guarantee of volume of business or income, and payment may be set locally or organised through the national Tariff system.

As a result, the AQP model is expected to be less attractive to larger independent healthcare providers than to local HCPs, though much will depend on the type of MSK service, ie: whether a potential provider's core interest is in elective treatments (e.g. joint replacements) or community based, long term condition management, assessment and diagnostics (e.g. Integrated Clinical Assessment and Treatment Service [ICATS]).

The prime vendor model allows part or all of a programme budget, such as that for MSK services, to be devolved to a provider who shares responsibility for commissioning services across an integrated care pathway. The prime vendor may engage other providers or subcontract parts of the budget to specialist providers in the patient pathway, as necessary.

This model can encourage integrated working, whilst not diminishing choice, as GPs are still able to refer patients to providers other than the prime vendor. The prime vendor model is attractive because it combines patient accountability and responsibility.

But safeguards are needed to ensure that the prime vendor model:

- Is not anti-competitive
- Guarantees choice
- Includes decision-making information for patients
- Provides assessments of quality
- Refunds an agreed proportion of any efficiency savings to commissioners
- Provides agreed training to current and future staff
- Aligns clinical and financial responsibility and encourages a population approach to development of services
- Includes break clauses in contracts in case of poor service

The prime vendor model is not an all-or-nothing option. A prime vendor can initially take charge of part of a programme budget and gradually add responsibility for further service provision as the clinical commissioning group, and providers, become familiar with and confident about the arrangement.

Should you go to tender?

There are no hard and fast rules about putting services out to tender. Each case should be judged individually and the decision based on the results of the market assessment, how well current providers are delivering and their ability to adapt to changing requirements.

It is vital that the established Principles and Rules of Co-operation and Competition (PRCC)¹³ are carefully considered before arriving at a conclusive course of action in relation to procurement. In July 2011, the NHS Co-operation and Competition Panel, set up in 2009 to advise on and investigate breaches of the Principles and Rules, drew attention to the high proportion of PCTs which were limiting patient choice for place of treatment – in contravention of government policy. Concerns were also raised over the use of minimum waiting times before treatment could be started.

The Panel felt that this was not an acceptable means of rationing care. Commissioners should therefore be aware of anti-competition regulations and consider taking legal advice over the need for medical indemnity to cover commissioning activities and any possible legal challenges that may result from commissioning decisions.

Good quality market assessment is a critical step within the tendering process as it acts as a differentiating point within the decision making process. For example, there would be little point offering a broad tender opportunity if market analysis shows that there is insufficient interest from providers to attract serious and capable bids. Likewise it would be irrational to discount the opportunity to attract potential efficiency savings in favour of local arrangements if the key quality and performance outcomes are below acceptable standards.

New contracts for MSK services should never be handed to providers just because they are known to be good at their job. But if a provider can clearly demonstrate that their expertise and staffing match the requirements of the service specification, there may be no need to put the service out to tender.

Part of the role of the commissioners is to support providers in developing additional

capacity and capabilities. In some cases, it will be more appropriate to encourage providers to collaborate than to tender for new providers.

Decisions to change providers need to consider the knock-on effects for other services. In some cases, providers may be relying on the profitability of a chronic illness service to support other, equally important but loss-making acute services, and vice versa. Taking away a pivotal service can have major consequences for the continuing viability of the provider and should be taken into account when change is planned.

What makes a good tender proposal?

The primary need is for an efficient and sustainable local MSK supply system that also has a contract that is secure. Commissioners need to be convinced that potential providers can deliver what they promise. This is easier to assess when a provider's expertise and workforce are well established than when the workforce will only be recruited once the contract is signed. A provider must therefore be able to demonstrate that all components of a service will be up and running within the stipulated timeframe. This is no small undertaking, as it should be expected that the quality of patient care and the experiences they report are at the highest standards from day one.

The volume of activities can be staged and escalated in line with an agreed deployment plan. However, potential providers should understand that quality aspects are non-negotiable and not subject to "gearing up", and that contracts can be made void if contracted services are not delivered.

Local clinicians or other HCPs who want to become AQPs may have the advantage of local recognition and knowledge, but they still need to demonstrate that they can deliver an efficient service. Larger, more established providers will know how to tender but may not have the confidence of local GPs.

Cost should not be the decider unless two or more providers can clearly demonstrate that they can meet the service specification. Even then, it may be advantageous to choose a provider that can offer an enhanced service rather than a provider that can do it cheaper.

Tenders need to:

- Answer the questions asked by the clinical commissioning group
- Demonstrate an ability to deliver integrated care
- Show how clinical competence is measured and monitored, education and training included and funding ring-fenced
- Provide innovative, but practicable, ideas for improving services
- Include examples of previous successful roll-out of MSK services
- Demonstrate a good understanding of the local population, eg: ethnic sensitivities
- Demonstrate a good knowledge of current services and evolving future needs
- Be able to deliver the aims of commissioners applicable to MSK services
- Be able to put in place acceptable (and mandatory) reporting systems

Potential providers of MSK services include:

- Local clinical groups – these are likely to have the advantage of better local knowledge, but may be less skilled at producing business plans. They may also have less capacity to ‘pump prime’ their business plan, and to recruit at risk, and so may need a longer lead in time for implementation of an expanded service.
- Independents (eg: Circle Health, Care UK) – these are likely to be well resourced, and able to provide highly professional business plans. If they are unable to offer all the required services, they may look for local gaps and fill niches. If they can provide a broader integrated service, they may be able to out-bid on price.
- Joint ventures e.g. local clinical experts and commercial partner and/or NHS Foundation Trust

Incentivising quality

There is a key role for quality incentives, both financial and non financial, in assisting effective commissioning.

Financial incentives for providers include:

- Withheld payments – where the quality threshold expected is not adhered to, for example if data are not submitted according to contracts or required waiting times are not met
- Best practice tariffs – being introduced to recognise best practice care, eg: for MSK surgery for ‘fractured neck of femur’; length of hospital stay
- Commissioning for Quality and Innovation (CQUIN) indicators – these make a proportion of provider income conditional on locally agreed quality and innovation goals. In 2009-10 this accounted for 0.5% of a provider’s contract value, rising to 1.5% in 2010-11. When CQUINs become the responsibility of the NHS Commissioning Board, they are likely to play a greater role, providing a key lever to improving the quality of care delivered, and not just rewarding target achievement. MSK CQUINs currently in use include:
 - Earlier discharge
 - Reduced re-admission rates
 - Improved patient experience

Other options could include:

- Access to a clinical nurse specialist
- Implementation of enhanced recovery programmes

The non financial incentives for providers are:

- Peer group pressure – use of data, accountability for performance
- Professional pride and recognition
- Linking performance improvements to career development

How are the commissioners performing?

Clinical commissioning groups will not just be PCTs by another name. They will be accountable to the National Commissioning Board, to patients and, not least, to local GPs and other HCPs. There is currently no guidance on assessment of commissioners, but assessment is likely to be based on their success in:

- Managing service demand and variation within primary care
- Ensuring access to and quality of service
- Improving the long term management of MSK disorders
- Engaging the entire clinical community, including patients, in care
- Ensuring an evidence based approach to service commissioning
- Promoting research and development

The Commissioning Outcomes Framework is likely to provide financial rewards to commissioners for delivering improvements in quality and outcomes, while the key non financial driver will be the publication of a commissioner's performance against the Quality, Innovation, Productivity and Prevention (QIPP) programme.

What makes a good MSK service?

Summary

- A good MSK service needs to include preventive care, acute and chronic treatment of common disorders, with provision for “rarities”, and incorporate research and training
- It should be built around integrated care pathways, with seamless transition for patients between different levels of care and specialties
- A community-based MSK service encourages greater primary care involvement and is generally more convenient to patients, but many specialist centres are also at the centre of large communities
- Effective triage lies at the heart of an effective MSK service and can be led by whichever local HCP has the most appropriate expertise
- A community based multidisciplinary team (MDT) is a valuable resource for assessing MSK patients and providing a broad range of treatments – from information and advice, through exercise prescriptions, physiotherapy, podiatry, chronic pain management, drug therapies and occupational therapy
- Good communication between all those involved in the MSK service – not just at major interfaces – is essential

An MSK service needs to offer competence across a broad range of specialties, including provision for “rarities”. It needs to accommodate preventive care, as well as treatment of acute episodes and management of chronic problems. It needs to be built around integrated care pathways which bring together all the clinical specialties associated with MSK management, breaking down barriers between primary care and hospital rheumatologists and other consultants, and ensuring appropriate input to address social care requirements.

It needs to provide effective access to the whole MDT, be informative, responsive, navigable, convenient and effective. It also needs to educate at all levels - HCP and patient - and provide training for the next generation of MSK specialists.

Research is a core NHS role, and the new knowledge that this provides in the prevention, diagnosis and treatment of disease is especially important in a climate of financial pressure. A good MSK service will be able to demonstrate its ability to “unlock” the synergies that exist between good patient care, education and research.

NICE guidance including clinical guidelines (eg: rheumatoid arthritis, osteoarthritis, low back pain)^{9,10,11}, the commissioning guide to biological drugs for inflammatory conditions¹⁴, and technology appraisals for individual drugs and procedures will inform MSK service development. Professional organisations, such as the British Society for Rheumatology and the British Orthopaedic Association, also publish MSK-related guidance. ARMA has produced Standards of Care for a number of MSK conditions, together with tools to assess services against these standards for some conditions. In addition, the Rheumatology Futures Group has published an Inflammatory Arthritis pathway, which can be found on the Elective Care Commissioning Pathways page of the DH website.

MSK patients may need:

| | | | |
|----------------|----------------------|---------------------|---|
| GPs | Physiotherapy | Rheumatology | Orthopaedics |
| Nursing | Podiatry | Rehabilitation | Social care |
| Education | Exercise | Dietetics | Psychological medicine |
| Bone screening | Information | Pharmacy | Self care |
| Pain control | Occupational therapy | Occupational health | Relevant voluntary sector organisations |

A small number of patients with rare, often life-threatening, conditions are likely to need access to more specialised, multidisciplinary clinical expertise which may not be available amongst all MSK providers. This might include patients with multisystem autoimmune disease (e.g. complex vasculitis and connective tissue diseases, particularly during pregnancy), and patients who require complex orthopaedic surgery (e.g. cervical myelopathy).

Hospital vs community

Only a small proportion of MSK patients require either hospital admission or an investigation or treatment which requires equipment that can only be found in a hospital environment. As a result, there is growing support for a more office-based service and/or outreach clinics held at places which are most convenient to patients.

The quality of the MSK service is more important than the building which houses it. But the decision about whether it should be hospital or community based is likely to depend on local geography and facilities, skills and expertise.

A hospital-based service has the advantage that specialist expertise is on-hand, but leaves specialists on site so they are available to handle emergencies within the hospital. It also supports the continuing viability of district general hospitals which risk losing “critical mass” if all but emergency services are sited elsewhere. In addition, some patients support the idea that their specialist care is provided at specialist centres, many of which are located in the centre of large communities, with good transport links.

A community-based service encourages greater primary care involvement and is more convenient to patients if it reduces the time and cost of travelling for appointments and investigations. It can be designed to ensure that necessary expertise is available when required, with specialists holding joint clinics with GPs and other members of the primary care team.

Needing less space to house large pieces of equipment than their predecessors, many of today’s physiotherapists are already based in primary care, and some GPs are “prescribing” health authority or council-subsidised exercise programmes at local sports facilities for patients with MSK and other conditions¹⁵.

Growing use of “virtual meetings”, teleconferencing and Skype also has great potential for optimising communication and use of specialist expertise within and beyond a community-based MSK service. In the longer term, developments in electronic patient held records will facilitate MSK care in a variety of settings – from consultation rooms to MDT clinics and sports centres.

Wherever the MSK service is positioned, it needs to be seamless. Clear and well established lines of communication between all members of the MSK service, at all stages of care pathways, will help to ensure that there are no barriers at any of the potential interfaces between primary care and specialist providers. Performance management of key pathways can help avoid unwarranted variation.

A role for triage and Choose and Book?

Triage can take MSK patients closer to their appropriate point of care, with less delay, than is possible through more traditional primary care referral systems. This is especially important for MSK patients with conditions where delay in specialist assessment can have serious acute and/or long term adverse consequences. Instead of referring patients to a rheumatologist, Tier 2 or other specialist, the GP sends the referral letter to the triage service where MDT members (including orthopaedic surgeons, rheumatologists, physiotherapists and occupational therapists) make an assessment and recommend the most appropriate care pathway. Appointments can then be made through Choose and Book.

Much depends on the quality of the referral letter and communication between the GP and triage service, and the skills of the triage team. Inadequate patient history in referral letters or failure to maintain good telephone and email contact (in both directions) can quickly turn triage from a facilitatory service into just another layer of bureaucracy. Training of the MDT in reviewing patient letters is essential as is monitoring variation in their recommendations for the most appropriate care pathway.

In some parts of the UK, Tier 2 services in rheumatology screen MSK patients referred by local GPs – managing those who do not need to see a consultant in secondary care and ensuring that those who are referred get any necessary investigations before seeing a consultant.

In some areas, Clinical Assessment and Treatment Services (CATS) have taken on the triage role and may provide a similar or wider range of community-based treatment options than Tier 2. CATS give clinicians an increased role in designing and delivering services, and aim to reduce delays for patients, and inappropriate referrals to secondary care services.

With the introduction of clinical commissioning groups, MSK triage could fall within the remit of the consortium if sufficient MSK expertise is available to determine the most appropriate referral for each patient, or triage could be included within the specification for Prime Vendors.

Supporting informed choice

By providing recommendations for referral, triage should not bypass the MSK patient in decision making. Patients should be involved in shared decision making about choice of provider, choice of treatment, choice of healthcare professional and choice of location of care, ie: "No decision about me without me" .

Patient expectations can significantly affect perceptions of outcome, so patients need to understand what can and cannot be expected from their treatment or intervention. Time is well spent in listening to the concerns of patients and helping them to understand treatment options, so that treatment decisions match clinical need, and expected outcomes are achieved.

To assist patients to make choices, they will need access to:

- Decision aids – such as pamphlets, DVDs and websites designed to help people understand their options, consider the personal importance of possible benefits and harms, and participate in decision making
- Information prescriptions – links or signposts to guide people to sources of information about their health and care
- Voluntary sector advice – patient groups and charities which can provide a range of information to assist patients in how to manage their condition
- Access to personal care planning tools – such as the Personal Health Plan which allows people to have greater ownership over their care and treatment

Good Practice

Across the UK, innovative approaches to commissioning and provision of MSK services are already under way. They include such wide-ranging initiatives as a community-based MDT treatment service on the Welsh borders, prime vendor responsibility for a multi-million pound MSK programme in the Pennines, physiotherapy-led triage services in Scotland and agreement of rheumatoid arthritis commissioning standards across the East of England.

Though very different in their aims and achievements, each initiative was:

- a response to a clearly identified local need
- supported by good evidence of potential benefits
- championed by knowledgeable and energetic stakeholders

These and other examples of good practice described in the next few pages represent just a few of the exciting opportunities for optimising MSK services.

Pennine MSK Partnership

On 1 May 2011, the Commissioning for Oldham Group (COG) and Pennine MSK Partnership, in conjunction with NHS Oldham (formerly Oldham PCT), took clinical responsibility for commissioning the whole MSK pathway, including orthopaedics, rheumatology and chronic pain. COG itself was set up in 2007 to carry out practice based commissioning (PBC) on behalf of Oldham GPs, while the Pennine MSK Partnership provided a Tier 2 rheumatology service for Oldham from 2002 which evolved into an Integrated Clinical Assessment and Treatment Service (ICAT) in 2006.

Pennine MSK Partnership now works with the clinical commissioner to deliver a population based, integrated pathway for MSK conditions.

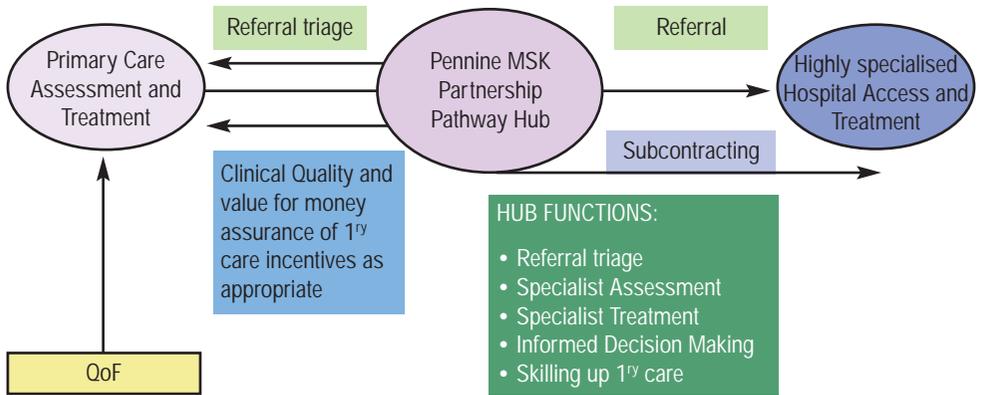
In effect, Pennine MSK Partnership has the role of Prime Vendor for COG, acting as a pathway hub whose role is to:

- Carry out referral triage, specialist assessment and treatment
- Support patients in informed decision making
- Enhance the skills of primary care colleagues

Patients who require highly specialised hospital assessment and treatment will be referred to sub-contracted providers (*Figure 7*).

The Partnership now holds the MSK Programme Budget for Oldham which ranked 28/152 PCTs in terms of MSK spend in 2008/2009. The new approach to MSK service provision in Oldham will deliver agreed savings in order to bring overall spend in line with regional levels and then national benchmarking. It is intended that spend will ultimately move within the upper quartile.

Figure 7. The Pennine MSK Partnership Pathway [with thanks to Dr Steve Laitner]



The Partnership expects to achieve savings by coordinating the primary care MSK pathway, working with local acute trusts to provide community based consultant opinion, and eliminating treatments with low clinical value. The Partnership is engaging closely with local and national patient groups and encouraging self care by providing personal care plans for patients with long term conditions, including self referral along agreed lines. The Partnership will commission pathways for patient admissions that will ensure 18 week compliance and best practice.

Key performance indicators for the community hub will include:

- Delivery of agreed efficiencies
- 18 week compliance
- Activity maintained with plan
- Patient experience

Benefits for providers have also been identified, including:

- Effective utilisation of capacity
- Appropriate referrals for surgical conversion
- Efficient use of workforce
- Increased surgical throughput as a result of Enhanced Recovery Principles and attracting back work from Independent Sector providers
- Maximal use of spare real estate as a result of Partnership hire of facilities
- Transfer of post operative follow ups to the community, if desired

Lessons learned

- There are many advantages from working in partnership with commissioners to remove unwarranted variation in the system
- Many savings can be made from investing in self care and self management
- Services work better when they are clinically run

East of England Commissioning Standards for Rheumatoid Arthritis

In 2009, the National Rheumatoid Arthritis Society (NRAS) initiated a project to promote implementation of NICE Guideline CG79, The Management of Rheumatoid Arthritis in Adults, against the background of the postcode lottery of care identified by the Kings Fund¹⁶, and publication of the Inflammatory Arthritis Commissioning Pathway, developed by the Rheumatology Futures Project Group and endorsed by the DoH¹⁷.

Having targeted Strategic Health Authorities (SHAs) and received a positive response from East of England SHA, NRAS established a working group with the National Ankylosing Spondylitis Society (NASS), the East of England SHA (Medical Director, the Chair of the Long Term Conditions Board) and 6 local rheumatologists to develop standards for commissioning services in RA and other inflammatory arthritides.

In 2010, 10 standards were agreed against which commissioned services can be measured, irrespective of the local commissioning model, including the goal that all patients with suspected inflammatory arthritis should be seen within an MDT approach within 2 weeks. Meaningful information about implementation of the standards was developed for local PCT and Consortium Commissioners. NRAS also drew attention to the scope for achieving a QIPP productivity and quality improvement and the potential savings in health care costs and increased productivity if joint damage is prevented. More information on this project is available on the Shared Learning database of NICE's Putting Guidance into Practice web pages.

Chronic Disease Self Management Programmes

Since 1994, thousands of people across the UK have learned how to live better with MSK and other long term diseases by attending self management programmes run by Arthritis Care, the Expert Patients Programme Community Interest Company (EPP-CIC) and other agencies. The National Rheumatoid Arthritis Society (NRAS) has also recently introduced a self management programme for people with rheumatoid arthritis, developed in partnership with EPP-CIC. Generic and disease-specific courses usually run over 6 weekly sessions of 2½ hours and cover areas, such as dealing with pain, depression and fatigue, relaxation and cognitive techniques, exercise, healthy eating, use of action plans and problem solving. A shorter two week course, Challenging Pain, is also available from Arthritis Care.

PCTs and PBC groups have commissioned courses as part of care pathways for chronic disease, and there is increasing evidence that courses result in long term improvements in pain and distress scores and make patients more confident about managing their symptoms¹⁸, as well as reducing GP, outpatient and A and E visits, and use of physiotherapy¹⁹. Such changes have been associated with cost savings, especially when courses are targeted at people with poorest health outcomes and introduced as part of their care pathway^{20,21}.

Lessons learned

- While providers of MSK healthcare may recognise the value of self management courses developed by charities and independent providers, some are unwilling to prioritise funding

Physiotherapy triage in Scotland

Physiotherapy triage for all adult routine orthopaedic referrals is being rolled out across the 75 practices of NHS Highland (total population 350,000). This follows a successful 12 month pilot scheme in three Mid Highland practices which showed that triage by an extended scope physiotherapist (ESP) resulted in a sustained reduction in the number of referrals into secondary care. During the pilot, 399 patients were triaged, either on paper, face to face or by telephone. Of these, 56.4% (225 patients) were able to be treated in a primary care setting either by an ESP, general outpatient physiotherapy, podiatry or orthotics service. Ten per cent of the group was able to be discharged with advice.

The original idea for the physiotherapy triage service arose in the urban setting of Inverness, where a practice-based ESP performed an informal triage role for local referrals to orthopaedic services at Raigmore Hospital. But it was decided to adapt this system to the needs of patients in the rural Mid Highland practices who previously needed to travel long distances for orthopaedic referrals.

Under the new system, GPs referred orthopaedic patients to an ESP who, having read referral letters and spoken to patients, decided on the most appropriate of several protocol-driven actions, ie:

- Physiotherapy
- Outpatient orthopaedic waiting list
- Advice leaflet
- Podiatry
- "Active referral"
- ESP
- GP with injection/aspiration skills/orthopaedic interest

For more information: http://www.improvingnhsscotland.scot.nhs.uk/case-studies/Pages/Triage_of_orthopaedic_ref.aspx

Lessons learned

- As local GPs became familiar with the triage initiative, referral letters became better tailored to the triage system
- Patients benefited because most could be treated more quickly in the community than under the previous system
- ESPs were chosen for the NHS Highland triage service as more physiotherapists had the necessary additional skills than GPs with orthopaedic expertise.

Community based services in Telford and Wrekin

GPs caring for the 160,000-strong population of Telford and Wrekin have a unique combination of referral options for their MSK patients – a daily consultant-led community rheumatology clinic or a Tier 2 community-based MDT treatment service where patients are triaged by a local GP with a specialist interest in (GPwSI) rheumatology and MSK medicine.

The community rheumatology clinic opened for business in August 2010 and was commissioned by NHS Telford and Wrekin to address chronic under provision of rheumatology services for Telford patients. A consultant rheumatologist was appointed to hold daily clinics for inflammatory arthritis (IA) patients referred directly by their GP. A GPwSI, physiotherapists and other MSK services are also available at these clinics. The service has capacity for 24 new patients per week, with a 6 week waiting time. However, there are plans to open an early arthritis clinic, with only a two week wait, with a performance indicator that all IA patients will ultimately be seen within 2 weeks.

The Tier 2 service is commissioned by local GPs, and provides specialist MSK treatment at a level between that of primary and secondary care services. It started in a small way about four years ago, as a hospital-based initiative, but moved to a community site in April 2011. GPs refer non-inflammatory MSK disorders to this service where a GPwSI reviews letters and sees patients or refers them to ESPs, physiotherapy, podiatry or chronic pain specialists within the service. The GPwSI runs two clinics per week, with capacity for 18 new patients per week and three follow-ups, and there is a six week waiting time. There are plans to extend the service to include an open access, walk-in option for patients without referral from their GP.

The key requirement for a Tier 2 service, such as that in Telford, is to have an appropriate mix of MSK skills at primary care level. A Tier 2 service is generally seen as more convenient for patients, and those with more minor conditions are likely to receive better care than if they have to compete with patients with more serious MSK disorders within a hospital service. A Tier 2 service should also reduce costs, as hospital referrals are reduced and fewer patients sent for unnecessary X rays, scans and other investigations.

Lessons learned

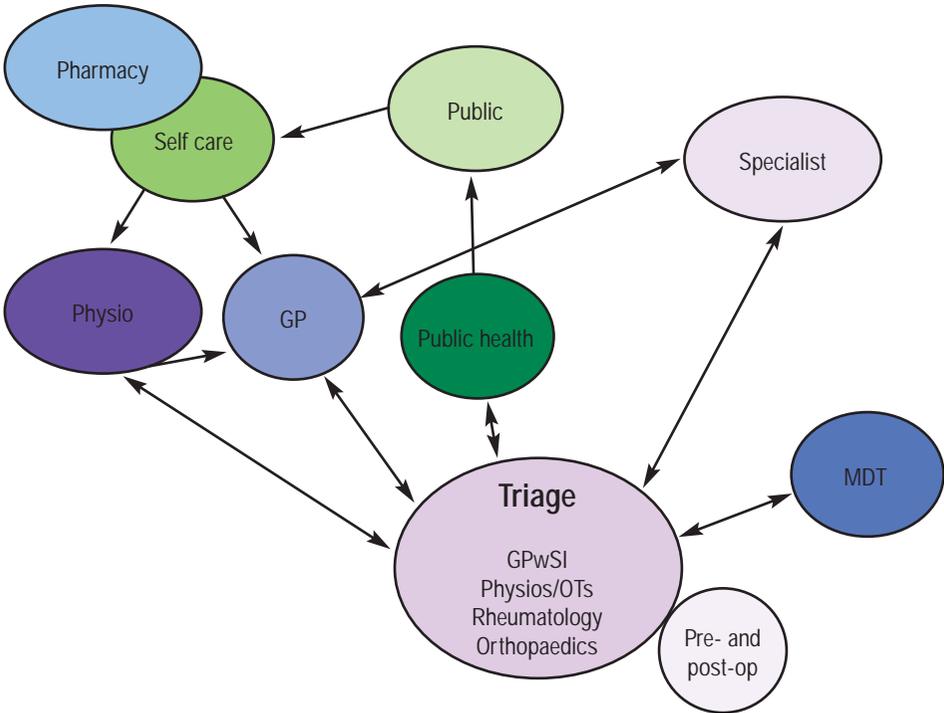
- There is a need for someone “on-the-ground” who is enthusiastic and motivated to drive this type of change.
- If acute trusts are unwilling to provide accurate referral data into orthopaedic and rheumatological services, it can be very difficult to “best guess” expected activity levels for new community-based services

A working model

From the outset, this Guide has stressed the importance of developing an MSK service which addresses the full range of patient, public health, NHS and social care needs associated with MSK disorders. It has also suggested that such a system must be sufficiently flexible to enable commissioners to adapt their services to local situations.

The MSK service pathway outlined in *Figure 8* shows how the key players might interact to facilitate timely patient access to the services and specialties they require. The pathway is not meant to be prescriptive, but suggests some of the interfaces to consider when developing an MSK service, adapted to local needs. The accompanying notes address some of the issues which may need to be addressed in order to optimise the MSK patient journey.

Figure 8: What an MSK Service Pathway could look like



Effective triage lies at the heart of an effective MSK service. But, as can be seen from the Good Practice initiatives, there are no hard and fast rules about who should carry it out, and much will depend on the availability of local expertise. Nor does triage have to be available for all MSK conditions from the start. For example, some ESP triage services have started with triage for back pain and gradually expanded to include other disorders.

Direct patient access to triage is generally inappropriate, but pathways should be established to facilitate self care, consultations with pharmacists and direct access to physiotherapy services.

A community-based MDT is a valuable resource for assessing MSK patients and providing a broad range of treatments, ranging from information and advice, through exercise prescriptions, physiotherapy, podiatry, chronic pain management, and drug therapies. However, in some areas which lack all this expertise at primary care level, the MDT may need to be hospital based – at least in the short term. When setting up an MDT, it is important to establish how this fits with triage, so that the entire MDT doesn't get involved in assessing every patient, but each member of the MDT is confident that triage will send them the most appropriate patients.

Access to all relevant hospital specialists is important, whether or not community based triage and MDT treatment are available. Rheumatologists specialising in problems such as vasculitis and connective tissue disease, and orthopaedic surgeons specialising in ankle problems will not be needed on an everyday basis, but pathways should be available to ensure appropriate referral for rarer MSK conditions.

Inter-specialty referrals need to be controlled as, in some cases, patients are better referred back to primary care before decisions about new referrals are made.

Interfaces may be multiple or focused at two key points: 1) between the patient and primary care and 2) between primary and secondary care.

Good communication between all those involved in the service – not just at major interfaces – is essential. This should include opportunities for patient feedback and audit of the patient experience.

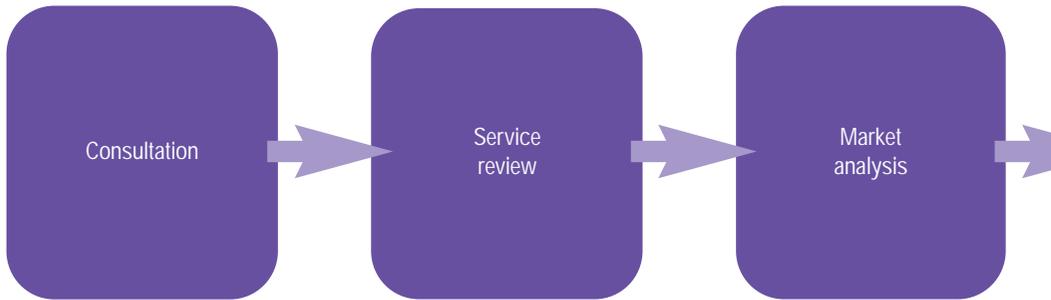
Cost containment is needed at key points in the patient pathway where costs are potentially high, and “expensive” people should not be performing roles which are within the remit of “less expensive” people. However, any cost control mechanisms included in the service should allow for a “big picture” analysis, and not just focus on reduced costs in the short term, at the expense of long term quality.

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Six Steps to Good Commissioning of MSK Services

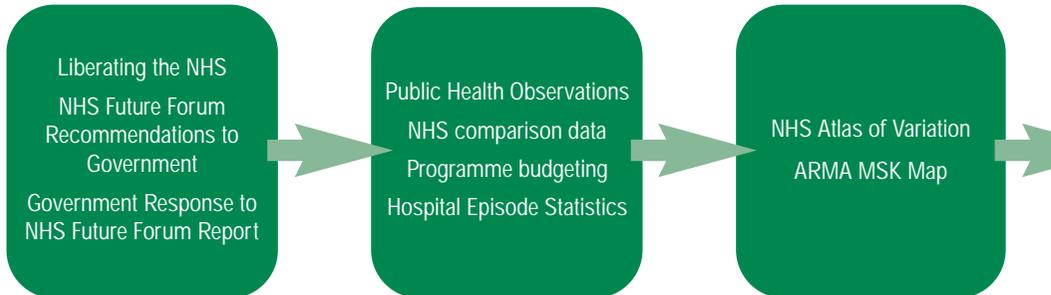
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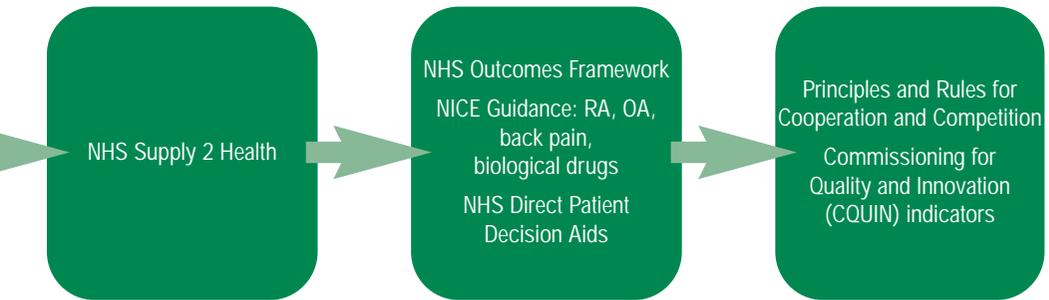
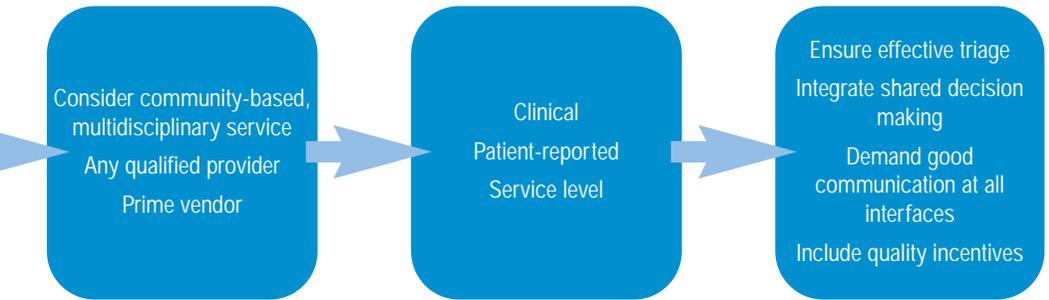
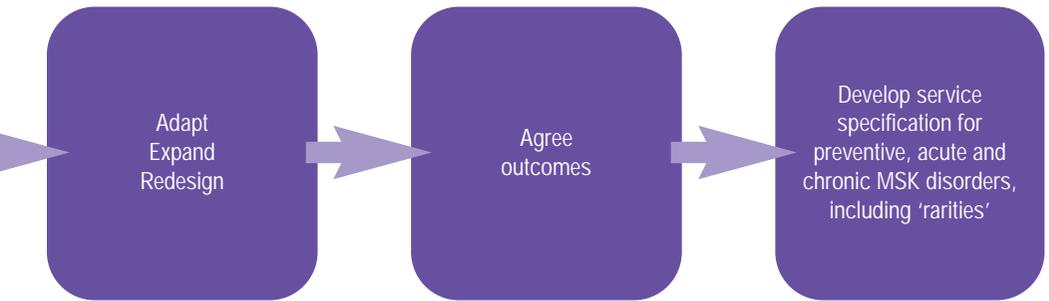


Checklist



Resources





Resources

Useful organisations

- Primary Care Rheumatology (PCR) Society aims to improve education in rheumatology in general practice, set up relevant research topics and increase communications between hospital rheumatologists and other relevant healthcare professionals, with the ultimate aim of improving care for patients with rheumatic diseases:
<http://www.pcrsociety.org/>
- Arthritis and Musculoskeletal Alliance (ARMA) is the umbrella body providing a collective voice for the arthritis and musculoskeletal community in the UK, and has 34 member organisations representing a broad range of interests across service user, professional and research groups working in the field of musculoskeletal conditions:
<http://www.arma.uk.net/default.html>
- British Society for Rheumatology (BSR) promotes excellence in the treatment of people with arthritis and musculoskeletal conditions and supports those delivering it:
<http://www.rheumatology.org.uk/>
- British Orthopaedic Association (BOA) aims to advance public benefit of the Science, Art and Practice of Orthopaedic Surgery with the aim of bringing relief to patients of all ages suffering from the effects of injury or disorders of the musculoskeletal system:
<http://www.boa.ac.uk/>
- Arthritis Care exists to support people with arthritis, and is the UK's largest charity working with and for all people who have arthritis. It runs chronic disease self management courses, Challenging Your Condition, Challenging Arthritis and Challenging Pain:
<http://www.arthritiscare.org.uk/LivingwithArthritis/Self-management>
- National Rheumatoid Arthritis Society aims to provide information and support for people with rheumatoid arthritis (RA), their families, friends and carers, and health professionals with an interest in RA.
<http://www.nras.org.uk/>
- Expert Patients Programme Community Interest Company (EPP CIC) provide and deliver free courses aimed at helping people who are living with a long-term health condition to manage their condition better on a daily basis:
<http://www.expertpatients.co.uk/about-us/what-we-do>
- Department of Health. Quality, Innovation, Productivity and Prevention (QIPP) – working to improve quality of care and make efficiency savings. Workstreams include five deal broadly with commissioning care, covering long-term conditions, right care, safe care, urgent care and end of life care.
<http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPP/index.htm>
- Right Care – one of 13 national QIPP workstream, it is focused on increasing value and improving quality by addressing unwarranted variation, by promoting use of health investment tools such as programme budgeting, and through sustainable systems and population planning.
<http://www.rightcare.nhs.uk/index.html>
- Co-operation and Competition Panel – provides advice about and investigates breaches of the Principles and Rules of Co-operation and Competition.
<http://www.ccp-panel.org.uk/>

Additional information

Map of Medicines Pathway, eg: Reducing health inequalities in MSK:

<http://www.mapofmedicine.com/mapinnhs/casestudies/reducinghealthinequalities>

Department of Health. Procurement guide for commissioners of NHS-funded services

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118218

Department of Health. A shared agenda in the new world: GP consortia and public health.

<http://www.sph.nhs.uk/sph-documents/gp-colloquium-final-report-1>

NHS Primary Care Commissioning: provides PCTs, GP commissioning organisations and providers with local insight into national policy and supports implementation and best practice in commissioning and contracting across all areas of primary and community care.

<http://www.pcc.nhs.uk/about>

NHS Networks: The Commissioning Zone – a portal for clinicians, managers and anyone else involved in commissioning. It brings together best sources and resources, to save time and promote sharing of useful information.

<http://www.networks.nhs.uk/nhs-networks/commissioning-zone>

The RCGP Centre for Commissioning. Created by the RCGP in conjunction with the NHS Institute for Innovation and Improvement, it exists to equip GPs, practices and GP consortia with the skills, competencies and expertise required to deliver effective healthcare commissioning

http://www.rcgp.org.uk/centre_for_commissioning.aspx

Shared learning: implementing NICE guidance: a searchable database of implementation initiatives.

<http://www.nice.org.uk/sharedlearning>

NHS Evidence: access to authoritative clinical and non-clinical evidence and best practice through a web-based portal.

<http://www.evidence.nhs.uk/>

NHS Direct. Patient Decision Aids to help patients make decisions about their tests and treatment.

<http://www.nhsdirect.nhs.uk/en/DecisionAids>

All links functional at time of going to press. If difficulties arise, please revert to organisation homepage and navigate to required documents.

Appendix 1:

NHS Outcomes Framework⁸: overarching indicators, improvement areas, indicators for improvement areas and NICE Quality Standards relevant to MSK

| Domain | Overarching indicators relevant to MSK | Improvement areas relevant to MSK | Indicators for improvement areas relevant to MSK | NICE Quality Standards relevant to MSK |
|--------|---|--|--|--|
| 1 | Mortality from causes considered amenable to healthcare | | | |
| 2 | Health-related quality of life for people with long term conditions (EQ-5D)* | <p>Ensuring people feel supported to manage their condition</p> <p>Improving functional ability in people with long term conditions</p> <p>Reducing time spent in hospital by people with long term conditions</p> <p>Enhancing quality of life for carers</p> | <p>Proportion of people feeling supported to manage their condition</p> <p>Employment of people with long term conditions using questions from the Labour Force Survey</p> <p>Unplanned hospitalisation for chronic ambulatory care-sensitive conditions (adults)</p> <p>Health related quality of life for carers to be collected through GP Patient Survey</p> | <p>Osteoarthritis</p> <p>Long-term condition/people with co-morbidities/complex needs[#]</p> <p>Safe prescribing</p> <p>Pain relief (to include young people)[#]</p> |
| 3 | Emergency readmissions within 28 days of discharge from hospital [~] | <p>Improving outcomes from planned procedures</p> <p>Improving outcomes from fragility fractures</p> <p>Helping older people to recover independence after illness or injury</p> | <p>Patient reported outcomes measures (PROMS) for elective procedures</p> <p>Proportion of patients recovering their previous levels of mobility/walking ability at i) 20 days and ii) 120 days</p> <p>Proportion of older people (65 years and older) who were still at home 91 days after discharge from hospital into rehabilitation services</p> | <p>Hip fractures</p> <p>Pain relief (to include young people)[#]</p> <p>Safe prescribing</p> |
| 4 | <p>Patient experience of primary care</p> <p>Patient experience of hospital care</p> | <p>Improving people's experience of outpatient care</p> <p>Improving hospitals' responsiveness to personal needs</p> <p>Improving patients' experiences of accident and emergency services</p> <p>Improving access to primary care services</p> | <p>Patient experience of outpatient services (using Outpatient Survey)</p> <p>Responsiveness to inpatients' personal needs (using Inpatient Survey)</p> <p>Patient experience of A and E services (using A and E Survey)</p> <p>Access to GP services (using GP Survey)</p> | Patient experience (generic) |
| 5 | <p>Patient safety incident reporting</p> <p>Severity of harm</p> <p>Number of similar incidents</p> | Reducing incidence of avoidable harm | <p>Incidence of hospital-related venous thromboembolism (VTE)</p> <p>Incidence of healthcare associated infection (HCAI): MRSA and C difficile</p> <p>Incidence of category 3/4 pressure ulcers</p> <p>Incidence of medication errors causing serious harm</p> | <p>Falls in a care setting</p> <p>Pressure ulcers in a care setting</p> <p>Safe prescribing</p> <p>VTE prevention</p> |

* EQ-5DTM is a trademark of the EuroQol Group. Further details can be found at: www.euroqol.org

Not yet referred to NICE for development

~ Indicator also included in the Adult Social Care Framework

Appendix 2: Possible outcomes measures for MSK services

| Outcome group | SLOMS | PROMS |
|-----------------------|---|---|
| Prevention | <p>Reductions in recurrent osteoporotic fractures</p> <p>Reductions in osteoporotic fracture risk (by using tools such as FRAX)</p> <p>Waiting time for MSK patient between first attendance at GP practice and first referral for specialist care (eg: physiotherapist, exercise, rheumatologist, or orthopaedic surgeon)</p> <p>Waiting time for rheumatoid arthritis patient between first symptomatic presentation at GP practice and treatment with disease-modifying anti-rheumatoid drugs (DMARDs)</p> | Limitation of self-reported occurrence of musculoskeletal pain |
| Acute single episodes | <p>Emergency readmission within 28 days of discharge</p> <p>Percentage of patients returning to pre-admission domicile</p> <p>Length of stay</p> <p>Re-operation rates</p> <p>Surgical complication rates</p> | <p>Percentage of patients self-reporting changes in pain and mobility after episode</p> <p>Percentage of patients self-reporting a return to function</p> |
| Episodic conditions | <p>Percentage of patients returning to work within n days of episode beginning (where research is required to define "n")</p> <p>Number of days off work amongst people with MSK disorders in contact with health services over a given time period</p> <p>Employment support allowance (ESA) claimed per head of MSK population during given time</p> | Percentage of patients self-reporting that they have returned to "normality" eg: self-reported return to work, absence of pain, or self-reported return to domicile |
| Long term conditions | <p>Percentage of patients returning to work within n days of episode beginning (where research is required to define "n")</p> <p>Number of days off work amongst people with MSK disorders in contact with health services over a given time period</p> <p>Disease activity score (DAS)</p> | Percentage of patients self-reporting that they have returned to "normality" eg: self-reported return to work, absence of pain, or self-reported return to domicile |

Appendix 3: NICE guidance relevant to MSK disorders^{9,10,11}

| | Key NICE recommendations |
|----------------------|--|
| Rheumatoid arthritis | <p>Referral for specialist treatment</p> <ul style="list-style-type: none"> • Refer for specialist opinion any person with suspected persistent synovitis of undetermined cause. Refer urgently if any of the following apply: <ul style="list-style-type: none"> - the small joints of the hands or feet are affected - more than one joint is affected - there has been a delay of 3 months or longer between onset of symptoms and seeking medical advice. <p>Disease-modifying and biological drugs</p> <ul style="list-style-type: none"> • In people with newly diagnosed active RA, offer a combination of disease-modifying anti-rheumatic drugs (DMARDs) (including methotrexate and at least one other DMARD, plus short-term glucocorticoids) as first-line treatment as soon as possible, ideally within 3 months of the onset of persistent symptoms. • In people with newly diagnosed RA for whom combination DMARD therapy is not appropriate, start DMARD monotherapy, placing greater emphasis on fast escalation to a clinically effective dose rather than on the choice of DMARD. • In people with recent-onset RA receiving combination DMARD therapy and in whom sustained and satisfactory levels of disease control have been achieved, cautiously try to reduce drug doses to levels that still maintain disease control. <p>Monitoring disease</p> <ul style="list-style-type: none"> • In people with recent-onset active RA, measure C-reactive protein (CRP) and key components of disease activity (using a composite score such as DAS28) monthly until treatment has controlled the disease to a level previously agreed with the person with RA. <p>The multidisciplinary team</p> <ul style="list-style-type: none"> • People with RA should have access to a named member of the multidisciplinary team (for example, the specialist nurse) who is responsible for coordinating their care. |
| Osteoarthritis | <ul style="list-style-type: none"> • Exercise should be a core treatment for people with osteoarthritis, irrespective of age, comorbidity, pain severity or disability. Exercise should include: <ul style="list-style-type: none"> - local muscle strengthening, and - general aerobic fitness. • Referral for arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis, unless the person has knee osteoarthritis with a clear history of mechanical locking (not gelling, 'giving way' or X-ray evidence of loose bodies). • Healthcare professionals should consider offering paracetamol for pain relief in addition to core treatment (see figure 2); regular dosing may be required. Paracetamol and/or topical non-steroidal anti-inflammatory drugs (NSAIDs) should be considered ahead of oral NSAIDs, cyclo-oxygenase 2 (COX-2) inhibitors or opioids. • Healthcare professionals should consider offering topical NSAIDs for pain relief in addition to core treatment for people with knee or hand osteoarthritis. Topical NSAIDs and/or paracetamol should be considered ahead of oral NSAIDs, COX-2 inhibitors or opioids. • When offering treatment with an oral NSAID/COX-2 inhibitor, the first choice should be either a standard NSAID or a COX-2 inhibitor (other than etoricoxib 60 mg). In either case, these should be co-prescribed with a proton pump inhibitor (PPI), choosing the one with the lowest acquisition cost. • Referral for joint replacement surgery should be considered for people with osteoarthritis who experience joint symptoms (pain, stiffness and reduced function) that have a substantial impact on their quality of life and are refractory to non-surgical treatment. Referral should be made before there is prolonged and established functional limitation and severe pain. |

| | Key NICE recommendations |
|---------------|--|
| Low back pain | <p>Information, education and patient preferences</p> <ul style="list-style-type: none"> • Provide people with advice and information to promote self-management of their low back pain. <p>Offer one of the following treatment options, taking into account patient preference:</p> <ul style="list-style-type: none"> - an exercise programme, - a course of manual therapy or a course of acupuncture. <p>Consider offering another of these options if the chosen treatment does not result in satisfactory improvement.</p> <p>Physical activity and exercise</p> <p>Consider offering a structured exercise programme tailored to the person:</p> <ul style="list-style-type: none"> - This should comprise up to a maximum of eight sessions over a period of up to 12 weeks. - Offer a group supervised exercise programme, in a group of up to 10 people. - A one-to-one supervised exercise programme may be offered if a group programme is not suitable for a particular person. <p>Manual therapy</p> <p>Consider offering a course of manual therapy, including spinal manipulation, comprising up to a maximum of nine sessions over a period of up to 12 weeks.</p> <p>Invasive procedures</p> <ul style="list-style-type: none"> • Consider offering a course of acupuncture needling comprising up to a maximum of 10 sessions over a period of up to 12 weeks. <p>Do not offer injections of therapeutic substances into the back for non-specific low back pain.</p> <p>Combined physical and psychological treatment programme</p> <ul style="list-style-type: none"> • Consider referral for a combined physical and psychological treatment programme, comprising around 100 hours over a maximum of 8 weeks, for people who: <ul style="list-style-type: none"> - have received at least one less intensive treatment and - have high disability and/or significant psychological distress. <p>Assessment and imaging</p> <ul style="list-style-type: none"> • Do not offer X-ray of the lumbar spine for the management of non-specific low back pain. <p>Only offer an MRI scan for non-specific low back pain within the context of a referral for an opinion on spinal fusion</p> <p>Referral for surgery</p> <ul style="list-style-type: none"> • Consider referral for an opinion on spinal fusion for people who: <ul style="list-style-type: none"> - have completed an optimal package of care, including a combined physical and psychological treatment programme and still have severe non-specific low back pain for which they would consider surgery. |

Appendix 4. A-Z of MSK diseases

There are over 200 MSK disorders, and the following list of conditions which might be treated within an MSK service is not exhaustive.

| Services | Treatment conditions |
|-------------------------------|--|
| Upper limb | <ul style="list-style-type: none"> • Repetitive strain injury • Shoulder bursitis • Rotator cuff tear • Frozen shoulder • Acromio-clavicular arthritis • Shoulder instability • Rotator cuff tendonitis • Biceps tendonitis • Calcific tendonitis/Supraspinatus calcification • Gleno-humeral arthritis |
| Hand | <ul style="list-style-type: none"> • Skeletal and soft tissue injury to the hand and wrist • Peripheral nerve injury/compression (e.g. carpal tunnel) • Osteoarthritis • Work related musculoskeletal disorders • Tendon injury • Hand/wrist problems related to rheumatic conditions • Dupuytren's disease |
| Hip and knee | <ul style="list-style-type: none"> • Hip bursitis • Non-specific hip or knee pain • Greater trochanteric pain • Pubic bone/abdominal wall related pain • Cruciate ligamentous condition knee • Inflammatory hip or knee pain • Labral tear • Iliopsoas strain • Anterior knee/patellar pain & sprain • Meniscal condition knee • Osteoarthritis |
| Foot and ankle | <ul style="list-style-type: none"> • Heel spur and Plantar Fasciitis • Achilles tendonitis • Tibialis posterior/peroneal tendonitis/strain • Osteo-chondral defect ankle/foot • Hallux Valgus/rigidus • Sesamoiditis • Osteoarthritis • Ankle sprain/instability • Tarsal tunnel syndrome • Medial gastrocnemius strain • Anterior/posterior ankle impingement • Metatarsalgia • Hammer toe • Tailor bunion |
| Back | <ul style="list-style-type: none"> • Chronic lower back pain • Mechanical back pain • Facet syndrome • Spondylolysis/lithesis • Non-specific back pain • Discogenic back pain • Spinal stenosis |
| Rheumatology | <ul style="list-style-type: none"> • Inflammatory arthritis • Osteoporosis • Connective tissue disease and psoriasis • Osteoarthritis • Reactive arthritis • Gout • Fibromyalgia |
| Cognitive Behavioural Therapy | <ul style="list-style-type: none"> • Psychological aspects of pain |
| Chronic Pain | <ul style="list-style-type: none"> • Medically unexplained symptoms of pain • Myofascial pain syndromes • Chronic regional pain syndromes • Neuropathic pain • Trigeminal neuralgia • Temporomandibular joint disorder • Angina pectoris • General musculoskeletal pain • Headache (including migraine) • Post-thoractomy pain • Stump and phantom limb pain • Herpes Zoster and post-herpetic neuralgia • Diabetic neuropathy • Post-mastectomy pain • Chronic Visceral pain syndromes |
| Generic | <ul style="list-style-type: none"> • Obesity or people with BMI greater than surgical acceptance limits • Osteoporosis assessment and management |
| Health Promotion/Prevention | <ul style="list-style-type: none"> • Falls prevention • Facilitate return to work |

AC Publications Limited
127 High Street
Rickmansworth
Hertfordshire,
WD3 1AN

Price: £5.00 (GBP)
ISSN 2040-3186

