Learning from best Practice

Musculoskeletal conditions as a health priority

The role of clinical networks

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Date: 13 October 2014
MSK in the NHS England (£5 -7bn)
4th largest area of spend

- More years lived with MSK disability than any other disease
- 2nd cause of disability
- More time off work
- 25% of all GP slots
- etc etc
- Not Kids, Cancer, Cardiac
- Is it a priority for payers?

- Under the Spot light
  - Economy
    - Expensive
  - General Election
    - Waiting times
  - Work
    - Benefits
The “new” NHS in England

What has changed?
• A mandate, separation of politics from running
• Clinically led rather than management led
  – Long-term conditions, NCDs, CCGs
• Focus on Outcomes not just volume and targets driven
• Localism, commissioning for local needs CCGs
• Patient/Person focused
  – Empowerment, self management, shared decisions
  – Individualised Care Plan
  – Evidenced based Pathways of care
  – Outcomes
• Freedom to commission new services
• Delivering value - outcome/cost
Models of Good Care

Good care:
• Transcends contractual arrangements that underpin it
• Is not the preserve of primary or secondary care
• Needs to be delivered by a wider team
• Needs to be integrated
  – across providers, carers, local authorities and employers
• Needs to be seamless in its delivery, user understanding it
• Needs to be delivered in appropriate settings
  – Near home / specialist centre
• Health Care Workers competent in delivering MSK care
  – Developing the MSK workforce
• user-driven; by needs, preferences and outcomes
• Prevention, public health, employment, social care.
Organisational and Clinical Processes

- Information and technology
- Care Planning
- Safety and Experience
- Guidelines, evidence and national audits
- Care Delivery

Informed and engaged patients and carers

- Self management
- Information and Technology
- Group and peer support
- Care Planning
- Carers

Person centred-coordinated care

Commissioning

- Needs Assessment and Planning
- Joint commissioning of services
- Metrics and Evaluation

- Service User and Public Involvement
- Contracting and procurement

- Care Planning
- Tools and levers

Health and Care Professionals committed to partnership working

- Integration
- Culture
- Workforce
- Technology
- Care Co-ordination
- Care Planning

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Networks are everywhere

- We are born into networks
- We live in social, cultural, religious, service networks
- Our health care is delivered by a network

- Are these networks conducive to a long and healthy life?

- No - They need to do better
  - Better outcomes
  - More efficient
  - Deliver better value (individual and society)
MSK is part of a wider networks
The ARMA Project: 
Key findings so far (1)

• Why it’s important
• Key issues for MSK services:
  • Inadequate understanding
  • Under-referral for rheumatology, over-referral for orthopaedics?
  • Right care, right place, right time. Effective triage
  • Role of AHPs and nurses
• Good MSK services:
  • Address urgent need
  • Tailored to personal needs and wishes
  • Improve quality of life
  • Support people to remain active (eg in work) and independent
The ARMA Project: Key findings so far (2)

- Successful implementation of innovative MSK services involved:
  - links with CCG/secondary care specialists
  - pioneering and innovative clinician/AHP; a “champion”
  - knowledge of change management
  - prior specialist training in MSK
  - persistence(!)
A shared vision for excellent MSK services

- Holistic patient-centred care
- Early intervention
- Improved clinical and personal outcomes
- Multidisciplinary with shared decision-making
- Co-ordinated care, empowering informed patients
- Maximises community-based care closer to home
- Excellent communication channels
- Effective and accurate monitoring systems
The “architecture” of MSK clinical networks

- Workforce: education and training
- Integrated, community-based care
- FLS (specific projects)

- Metrics / outcome measures
- Patient involvement

Regional (SCN) level

Local (CCG) level
Workforce: education and training

- Direct Assess to Physiotherapy (Scotland)
- Community Pharmacy

- The musculoskeletal Practitioner
- BSR, BOA, CSP, RCN, Keele University etc
  - Physio, Nurse, OT, Radiographer
  - Rheumatology nurse practitioner,
  - Trauma co-ordinator
  - Fragility Fracture Co-ordinator
- National Transferable roles

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Integrated, community-based care

- Many examples
  - Local MSK

- Effect on the whole system
- Trauma and planned orthopaedic

Fracture liaison Service
- “A no brainer”
Metrics / outcome measures

- Making metrics part of the day job (ARUK)
- Should the NHS buy anything it does not measure
  - Provide an estimate of disease burden
  - Musculoskeletal Calculator
  - Effectiveness of processes
    - (Best practice tariff NOF)
    - (Best practice tariff early rheumatoid)
  - Pre treatment level of severity
  - Outcomes after treatment
  - Health gain (Best practice taffice
Pathway Stage - Access / Outpatients
Metric – Conversion Rates
Chart 10: Condition-specific measures: percentage of responses indicating improved or worsened health, by year

- **Oxford Hip Score**
  - 2011-12: 95.7%
  - 2010-11: 95.8%
  - 2009-10: 95.7%

- **Oxford Knee Score**
  - 2011-12: 91.6%
  - 2010-11: 91.4%
  - 2009-10: 91.4%

- **Aberdeen Varicose Vein Questionnaire**
  - 2011-12: 83.1%
  - 2010-11: 82.5%
  - 2009-10: 83.4%

**NOTE:** There is no condition-specific measure for Groin Hernia
Outcome Relates to Pre-op Function*

*from PROMs Data April 2010
Figure 6: Hip Replacement Oxford Hip Score\textsuperscript{10}

- **Hip Replacement OHS average pre-operative score**
  - 18.75 to 21.95 (37)
  - 17.81 to 18.75 (35)
  - 16.59 to 17.81 (40)
  - 13.9 to 16.59 (39)
  - No Data (0)

- **Hip Replacement OHS average post-operative score**
  - 36.6 to 43.6 (38)
  - 37.3 to 38.6 (33)
  - 35.9 to 37.3 (40)
  - 32 to 35.9 (40)
  - No Data (0)

- **Hip Replacement OHS adjusted average health gain**
  - 20.3 to 21.95 (36)
  - 19.6 to 20.3 (35)
  - 18.59 to 19.6 (37)
  - 15.55 to 18.59 (39)
  - No Data (4)
Intelligence Network - Dashboard

- MSK dashboard for each provider. Data sources include:
  - NJR
  - IANA
  - HES
  - HSCIC
  - NHS Comparators
  - NHS Indicators
  - Productivity Metrics
  - PROMS
  - National data sources – waiting times etc
  - National Hip Fracture Database
  - NHS Litigation Authority
  - NHS Atlas of Variation
  - Arthritis Research UK Musculoskeletal Calculator.
Affiliation to the Project

- The MSK Stake holders 40+ (Patients, Charities, Professions)
- Commissioners
- Providers
- NHS Confederation
  - Organisations across the NHS vertical and horizontal
- NHS England
- DH
- Politicians
The importance of networks

Aim: fully Integrated, patient focused care

Networks are key
• Centrally funded, locally delivered care

The “network society”: a society where the main activities in which people are engaged are organised fundamentally in networks, rather than in vertical organisations. Manuel Castells, sociologist

Building a community around a shared purpose enhances ‘social capital’ – the benefit derived from when individuals and groups cooperate. Investing in social capital is essential when navigating turbulent and volatile environments.
Effective Networks in Healthcare, Health Foundation (March 2014)
Networks and integration

Put simply, integration should become the main business for health and social care". At heart, it's about continuous, coordinated care.

King's Fund

Care planning for long-term conditions
“When you are done changing, you're done.”

Benjamin Franklin
We are not done

MSK is a priority – The writing is on the wall

Networks are the future