ARMA Key messages for commissioners

Summary of key messages:

1. Delivering MSK care well **represents good value**; saving money and improving outcomes

   1. a. Commissioned services must have an emphasis on prevention, both primary and secondary.

   1. b. Early diagnosis and intervention is essential, particularly for inflammatory forms of arthritis

   1. c. Cost-effective treatments such as orthopaedic surgery should not be rationed or subject to arbitrary thresholds.

   1. d. Rehabilitation, reablement and self-management are key aspects of a patient-centred approach

2. MSK needs must be written into the **Joint Strategic Needs Assessments (JSNAs)**

3. The use of **accredited guidance and clinical expertise** in the commissioning process is crucial

4. MSK **patient groups need to be genuinely involved** in commissioning discussions, and their views sought

5. **"Patient-led" services** and services focused on patient empowerment are not an afterthought, and require investment

6. **Personalisation of care** is central to providing high-value services

1. Delivering MSK care well represents good value; saving money and improving outcomes

While mortality rates in the UK are falling, the Global Burden of Disease study (2010) illustrates how MSK disorders are the single biggest cause of the burden of disability in the UK - much of this is avoidable, through prevention and early intervention.

1. a. Commissioned services must have an emphasis on prevention, both primary and secondary.

- Osteoporosis and resulting fragility fractures represents a significant MSK problem. One of the most effective points of intervention is secondary fracture prevention via a Fracture Liaison Service (FLS), which systematically identifies, treats and refers to appropriate services all eligible patients aged over 50 years within a local population who have suffered a fragility fracture with the aim of reducing subsequent fractures.

- In 2009 a DH economic evaluation of FLS suggested that the potential saving to the NHS in England could be as much as £8.5 million over a five year period, i.e. approximately £290,708 per locality of 320,000[1].

- The National Osteoporosis Society has produced **resources** including FLS Standards, an FLS Implementation Toolkit and Fracture Prevention Practitioner Training to support the development of Fracture Liaison Services across the UK.

- The CSP has developed a useful **economic model on falls prevention**.

- Physical exercise can significantly reduce the elevated risk of developing comorbidities which many people with MSK disorders face as well as the pain associated with MSK conditions, or prevent the disorder altogether: up to half of all knee osteoarthritis is preventable by weight reduction.

- An emphasis on prevention can also result in shorter waiting times and effective outcomes, a reduction in primary care consultations and in inappropriate referrals to secondary care.

1. b Early diagnosis and intervention is essential, particularly for inflammatory forms of arthritis

Adequate recognition and understanding of inflammatory forms of arthritis, particularly in primary care, is essential. Accessing specialist treatment within the first 3 months from the onset of symptoms of rheumatoid arthritis (RA) could see a 4% improvement in quality of life over the first 5 years and could lead to remission or a low disease activity state, along with a reduction in mortality. Appendix 2 provides examples of integrated working.

1. c. Cost-effective treatments such as orthopaedic surgery should not be rationed or subject to arbitrary thresholds.

The estimated 10-year cost per QALY for hip replacement surgery is £4288, meaning that hip surgery costs less than £10 a week for sustained pain relief (Dias, Kay and Porter 2012). Where the replacement joint lasts 15 years without revision, this cost is only £7.50 a week (Briggs 2015). Furthermore, based on the 10-year QALY cost estimate, hip replacement surgery is approximately 7 times more cost effective than drugs priced at the threshold NICE use for Health Technology Assessment.

Any decision to ration orthopaedic surgery presents a significant risk to patients given that orthopaedic referrals are rising at a rate of 7-8% a year, showing clear and growing clinical need. Given that Orthopaedic surgery is highly cost effective, with a QALY cost for hip replacement of £4288, rationing access to these interventions would also limit CCGs' ability to maximise population health within a fixed budget. While we recognise the need to prioritise resources, this should be based on patient need and on proper evidence about which interventions are most effective.

[1] Department of Health, 2009a17

Decisions to refer or operate should be a shared decision between clinicians and their patients, after consideration of all relevant treatment options. There is no single referral threshold tool that can replace this discussion between clinician and patient. Often the decision not to offer surgery is the most important outcome for the patient. Patients' informed choice of treatment, however, must not be automatically restricted by thresholds based on lifestyle or body mass index, among other things.

1. d. Rehabilitation, reablement and self-management are key aspects of a patient-centred approach

There is significant evidence that the above improves outcomes, restores people's ability to perform usual activities, improves their perceived quality of life and is cost-effective. These should become a core element of health and care services in the community, including following discharge from secondary care.

Clearer and better planned discharge from hospital can also cut down re-admission, as identified by the **Royal College of Surgeons.**

Vocational rehabilitation aims to help people access employment or work opportunities and retain or regain employment by addressing barriers and obstacles to work. These barriers may include impairments related to health conditions or injury, economic conditions and employers' lack of confidence when dealing with employees with disabilities or long term conditions.

2. MSK needs must be written into the JSNAs

With MSK needs form an important part of local health planning, and writing them into the JSNAs will encourage clinical commissioning groups and local partners to plan for MSK needs fully. It will support planning based on competencies rather than professions or historical roles and encourage and outcomes-based approach and collaboration between different providers.

AR-UK's **MSK calculator** provides commissioners with an estimate of the prevalence of musculoskeletal conditions.

ARUK's report 'A *Fair Assessment? Musculoskeletal Conditions-The need for local prioritisation'* from March 2015 found that:

- The range of knee OA alone for every local authority area is 15-21%
- Despite this, only 36% of local authorities include OA in their JSNA-all should
- There is a fundamental unfairness that needs to be addressed here to ensure good commissioning decisions are made-some local authorities with 20%+ prevalence in their local area have not included OA in their JSNA whilst others with comparatively lower prevalence have.

3. The use of specialist guidance and clinical expertise in the commissioning process is crucial

Knowledge of the evidence base is important to ensure appropriate pathways are included in planning. Incorporating the full range of clinical expertise in the commissioning process makes innovation in service provision more likely, and can help ensure that best practice is followed and avoid unintended consequences.

- 73% of CCGs studied by the Royal College of Surgeons do not follow NICE and clinical guidance on referral for hip replacement, or have no relevant commissioning policy in place.

ARMA's **"MSK 9"** list provides a guide to the key stakeholder groups that should be involved in decisions regarding the commissioning or redesign of MSK services.

4. MSK patient groups need to be genuinely involved in commissioning discussions, and their views sought

Commissioning decisions must be fully informed by adequate input and involvement from people living with MSK conditions at each stage of the commissioning cycle.

Services should be underpinned by patient choice and a process of shared decision-making. Patient choice of care must not be unduly restricted by rigid barriers or unwarranted thresholds for accessing treatment of proven value, as outlined above.

- The best ways of delivering shared decision-making include the provision of decision aids and supporting patients to use them; providing question prompts to help people interact during consultations; coaching and education to support patients to be more engaged and access to medical records. Please see National Voices' **simple guide** for more information.

- Services must also aim to enhance patient experience. Evidence from 110 systematic reviews by National Voices supports a focus on clear communication with patients, skills training for clinicians, continuity of care provision, the use of patient surveys and the public reporting of performance data to enhance patient experience. Please see National Voices' **simple guide** for more information.

5. "Patient-led" services and services focused on patient empowerment are not an afterthought, and require investment

Many "patient-led" organisations provide important and highly-valued services for people living with MSK conditions, including helpline support, self-management courses and peer support groups. These however require adequate recognition, investment and costing in service specifications, as appropriate, in order to be sustainable. Current examples of patient-led services in the NHS are provided in Appendix 2.

6. Personalisation of care is central to providing high-value services

National clinical guidelines often fail to account for complex health needs such as co-morbidities and individual social circumstances. Personalisation of care will improve the integration of different services and is important to improve outcomes and patient satisfaction.

The Year of Care tariff is one means by which to reduce unnecessary hospital admissions and encourage community based treatment.

APPENDIX 1

Commissioning: general

- Commissioners need to commission services on the basis of population need. This requires good needs assessments and the involvement of all key stakeholders.
- Commissioners should commission for improved patient outcomes, and for a reduced burden of disability
- The commissioning process needs to be robust and transparent
- Integrated MSK pathways are central to providing coordinated, patient-centred care. These need to be accompanied by effective treatment and referral guidelines to ensure that patients receive the right care in the right place and at the right time.
- The service spec has to be solid and well-costed. This should avoid any unintended consequences which may unduly affect services in a way that may directly impact on the value of the care being delivered.
- The value of care should be based on patient outcomes and experience, including as reported by patients themselves

About arthritis and musculoskeletal conditions

Musculoskeletal (MSK) conditions are conditions of the joints, bones and muscles, which also include rarer autoimmune diseases and back pain. There are more than 200 MSK conditions.

Musculoskeletal conditions:

- Affect more than 10 million adults and around 12,000 children in the UK.
- Account for up to 30% of GP visits in England.
- The single biggest cause of the growing burden of disability in the UK. Much of this is avoidable disability.
- Mental health and MSK conditions account for over half the overall burden of disability in the UK.
- Have an enormous impact on the quality of life of millions of people.
- Are associated with a large number of co-morbidities, including diabetes, depression and obesity.
- Account for more than £5 billion of NHS spending per year.

As the UK population ages and the number of people living with multiple long-term conditions grows, the burden of MSK conditions is set to increase. The number of referrals for orthopaedics is typically rising by 7-8% per annum, for instance. Yet MSK conditions remain chronically under-prioritised in the NHS.

National Voices: **evidence for person-centred care** and **participation guide for commissioners**

NHS England: **House of Care** **resources**

APPENDIX 2

Examples of integrated working

The University Hospital Southampton has implemented a dedicated biologics review clinic.

- The biologics review service realised annual cost savings of £446,000 due to patients switching therapy or reducing dose and £303,000 was saved due to patients stopping therapy or entering a clinical trial.

- To incentivise the hospital to make the initial investment, an innovative gain-share scheme was employed to share cost savings equally between the trust and commissioners

Guy's and St Thomas' has established an RA centre.

- It is estimated that the improved patient outcomes associated with the treat to target pathway at Guy's and St Thomas' reduces the need for two specialist nurse visits per patient per year. This equates to an annual saving of approximately £230,360 across all patients

- Guy's and St Thomas' treat to target pathway was found to have a lower used of biologics (13%) compared to routine care (20%) (2008 figures). This is associated with an estimated saving to commissioners of £1,118,412 per year.

Bristol Royal Infirmary implemented an evidence-based, standardised, multidisciplinary care pathway.

- Patients were involved in the service redesign from the outset and the service continues to involve patients in review meetings, which help to improve the service

- Patients receive education packs about their treatment, and specialist nurses encourage self-management as well as providing further education.

- Self-management clinics are held fortnightly to support patients in improving their fatigue, coping and well-being

Addenbrooke's established a one-stop early inflammatory arthritis (EIA) clinic at Newmarket hospital, to focus on fast diagnosis and treatment of patients with suspected EIA.

- A key role of the rheumatology practitioner is to provide education and counselling to patients about their disease and their treatments

- Depending on the emotional impact of the diagnosis, it is sometimes not appropriate to start treatment and education in the first visit. Such patients are offered to return to the clinic in two weeks, to ensure that they are fully prepared for starting treatment

- Occupational Therapists offer a four week patient education programme with four sessions lasting 2.5 hours each. The main aims of the programme are to teach patients techniques to manage pain, fatigue and how to protect their joints.

- In a 2013 patient satisfaction survey, 100% of patients agreed or strongly agreed that they were satisfied with their experience of the one-stop EIA clinic.