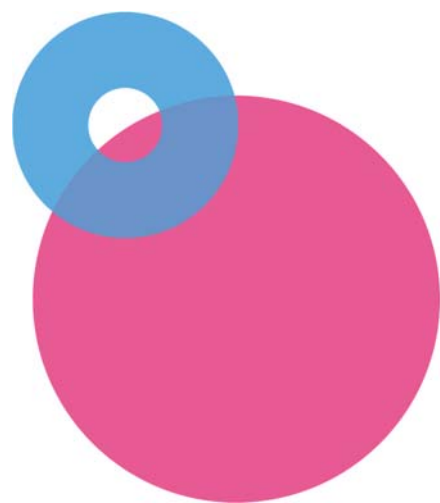


Developing MSK Networks





Foreword

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I am delighted to commend to you this important resource pack jointly produced by the NHS Confederation and ARMA. Much of the background work informing this resource was carried out by ARMA and originally funded by the Department of Health, in recognition of the importance of developing networks to improve MSK services in England. In my role as NHS England's National Clinical Director for MSK, I have been working closely with ARMA and the MSK community to bring together expertise and develop resources supporting the development of multidisciplinary clinical networks. Such networks drive improvement in MSK care across England, with patient outcomes at their heart. This is a living document and represents a very practical and useful tool to facilitate improvement. It will continue to be updated with further resources added to the online version.

At its core, this resource pack brings together principles of good practice in MSK to help CCGs clearly define and describe what successful MSK services could look like, could include and could achieve. There is no one-size-fits all solution. Different things will work well in different places, and solutions will need to be developed locally in response to local needs. However, there are clear benefits to adopting a 'networks' approach to tackling challenging condition areas like MSK, and all successful networks have certain things in common. In particular, it is only by working across all the different groups, involving all the key stakeholders and bringing together all of the evidence and expertise that exists within our broad community that we can define what a comprehensive MSK service that delivers co-ordinated person-centred care for all people living with MSK conditions can look like. I hope that this resource pack will serve to stimulate and provide practical assistance to many CCGs and healthcare professionals across the country who are either



considering or are already in the process of using a 'networks' approach to redesign and/or improve their MSK services.

Clinical networks represent an excellent means for improving care, improving value and improving outcomes for the many millions of people living with MSK conditions in England. However, they need to be built up, not imposed, and this is where this resource pack is of real, practical value.

Professor Peter Kay

National Clinical Director for MSK, NHS England

Contents

Contents	4
INTRODUCTION.....	5
SECTION A: Musculoskeletal Disorders	6
Musculoskeletal Disorders – how big is the problem?.....	6
What does all this mean?	7
Impact of MSK conditions on health and social care services	8
Wider economic impact of MSK conditions.....	8
SECTION B: Networks	8
What is a Network?	8
Why Networks?.....	9
What can local MSK networks achieve?	11
Who should be involved in a local MSK network?.....	11
Health practitioners delivering MSK care include:.....	12
SECTION C	13
Ensuring the effectiveness of MSK networks.....	13
Effective leadership.....	14
Developing a clear vision for MSK service improvements.....	15
Identifying priorities for action.....	15
ARMA/NHS England MSK network priorities:	16
Integrated MSK services.....	16
Workforce: Education and Training.....	17
Metrics	17
Fracture Liaison Services.....	18
Local Network Priorities	19
SECTION D.....	19
Commissioning.....	19
Resources for Commissioning	20
CONCLUSION.....	21

INTRODUCTION

MSK is a massive health challenge, and is costly to treat – and even costlier when treated badly. The escalating costs both human and financial cannot be ignored. There is much to be done and with increasingly strained resources. But there is no argument about what needs to be done. The NHS must focus on:

- coordinating resources more effectively
- delivering integrated services
- reducing duplication
- increasing service quality and improving patient experience and outcomes

Developing MSK Networks provides MSK commissioners and others with the guidance and support they need to create the local MSK networks that really can deliver high-quality, cost-effective care throughout the effective commissioning, organisation and monitoring of services.

Achieving this requires change and new ways of working. It calls for health and social care professionals to work in partnership with people with MSK conditions to deliver structured, personalised and integrated care that truly supports effective self-management, improving quality of life and reducing the burden on the NHS.

It calls too for having in place the right commissioning structures, effective procedures and clear channels of communication that connect people with MSK to the care they need – when they need it.

There are always risks associated with change. But the risks associated with not engaging all those in the MSK community in raising standards, and improving outcomes for people with MSK and their families, are far greater. It is through working collaboratively and using shared skills, knowledge and experience that we can bring about the change that is needed.

While initial impetus for MSK service change often comes from the cost of secondary care referrals, MSK service improvement requires a more comprehensive approach if it is to result in successful and sustainable change. Experts in MSK advise that it needs to be treated as a long-term condition, being aware that there are needs to support self-management, manage chronic pain, get an early and accurate diagnosis, and prompt referral to an appropriate care pathway.

SECTION A: Musculoskeletal Disorders

Musculoskeletal Disorders – how big is the problem?

MSK is a huge health challenge, which can be both painful for patients, often negatively impacting on the ability to work, and it is highly costly both to the health service and wider economy. With an ageing population, MSK is also a growing problem.

Musculoskeletal (MSK) conditions comprise a broad collection of more than 200 different conditions including acute trauma, recurrent conditions and long term conditions. These conditions affect bones, joints, muscles, and spine, as well as rarer autoimmune conditions. There are currently around 10.7 million adults that have a musculoskeletal condition in the United Kingdom today.ⁱ

Broadly three groups of musculoskeletal conditions can affect people, leading to poor musculoskeletal health.

- i) **Inflammatory conditions** – such as rheumatoid arthritis and ankylosing spondylitis, often requiring urgent referral and long term care planning.
- ii) **Conditions of musculoskeletal pain** – including osteoarthritis, and mechanical back pain, often requiring supported self-management, pain management and appropriate referral guidelines for joint replacement surgery with pre- and re-habilitation.
- iii) **Osteoporosis and fragility fractures** – requiring fracture care, rehabilitation, and support to prevent further fractures via fracture liaison services.

All conditions will require accurate diagnosis, appropriate referral where necessary, pain management, and potentially mental health support.

In addition to causing pain and disability, MSK conditions affect general physical health and interfere with people's ability to carry out their normal activities. People

with osteoarthritis have increased risk of cardiovascular diseaseⁱⁱ. There is substantially increased mortality for older people following a fall and a broken hip,ⁱⁱⁱ whilst many of the rarer inflammatory MSK conditions can substantially shorten the lives of those affected.^{iv}

MSK conditions also have a huge impact on mental health. Depression is four times more common for those people in persistent pain than in those without such pain.^v Two thirds of people with osteoarthritis report symptoms of depression when their pain is at its worst.^{vi} One in six people with rheumatoid arthritis has major depression.^{vii}

What does all this mean?

MSK disorders affect around ten million people across the UK and account for the fourth largest NHS programme budget spend of £5 billion in England¹. We now know that they account for the biggest part of the workload of the health service, 40% of which is due to potentially preventable risk factors. According to the latest Global Burden of Disease data, MSK conditions (notably low back and neck pain) emerge at the very top of the list of conditions with the highest DALY, i.e. Years of Life Lost (YLL) combined with Years Lived with Disability (YLD) – ahead of more “life-threatening” conditions such as COPD (4th), lung cancer (5th), and diabetes (11th).

MSK disorders specifically “consume a substantial amount of health-system resources”. Because they are also strongly age-related, they “will become increasingly prevalent as the population ages.”^{viii}

In England:

- 16.5 million people have back pain^{ix}
- 8.5 million people have peripheral joint pain^x
- 4.4 million have moderate or severe osteoarthritis³
- 650 000 have inflammatory arthritis^{xi}
- 400,000 women aged over 80 years have osteoporosis^{xii}
- 200,000 people have osteoporotic fractures each year^{xiii}

The prevalence of musculoskeletal disorders rises with age, and is higher in women than men at all ages. One-third of the population over 75 will have a chronic musculoskeletal problem.^{xiv}

Impact of MSK conditions on health and social care services

Each year 20% of the general population sees a GP about an MSK problem.^{xv} The NHS in England spends £5 billion per year on treating MSK conditions.^{xvi} The cost of treating hip fractures is calculated separately, and costs the UK around £2 billion annually in clinical and social care costs.^{xvii} MSK conditions are an important component of multimorbidity,^{xviii} and are a contributor to frailty.^{xix} For people with multiple long-term conditions having a chronic painful MSK condition independently increases the risk of needing to be admitted for hospital care.^{xx} The need for long-term social and residential care is often due to worsening MSK health, and pain and disability is a substantial barrier to independent living.

Wider economic impact of MSK conditions

Poor MSK health is a major barrier to workplace participation. People with MSK conditions are less likely to be employed than people in good health, and more likely to retire early.^{xxi} If employed, people with MSK conditions are more likely to need time off and have reduced household income compared to those who do not.^{xxii} This has a significant impact on the national economy; Disability Living Allowance (DLA) and Attendance Allowance (AA) figures for new benefit claims in 2011/12 saw MSK disorders to be the main disabling condition with 26.9% of claims falling into this category.^{xxiii} Each year in the UK around 7.5 million working days are lost because of MSK conditions, second only to mental health problems.^{xxiv} The costs of this, along with other indirect costs, are estimated at £14.8 billion for osteoarthritis and rheumatoid arthritis^{xxv} with up to a further £10 billion of indirect costs attributable to back pain in the UK.^{xxvi}

SECTION B: Networks

What is a Network?

Simply put, a network is a forum which gathers together stakeholders - including those with MSK conditions - with the key aim of working in collaboration across patient pathways to improve outcomes for people with MSK conditions. Networks of this nature that exist across local health economies help to enable service improvement and integrate care.

Typically, these networks will:

- Provide a safe forum to enable sustainable improvement to take place at a local level
- Develop a shared vision and priorities for network members to take back to their base organisation
- Influence stakeholder thinking through open communication channels
- Increase transparency across the care pathway, and open up shared resources and support across the member organisations

Networks can be defined as working relationships between trusted friends. While it can take time to develop genuine collaborative working relationships across the MSK and management professional groups, networks are a key means of helping to incrementally build trust across the disciplines in order to harness local clinical insight to best develop local services for local patients. (Alastair Mew - Head of Commissioning, Sheffield CCG)

Why Networks?

Networks have been responsible for making significant improvements in health and social care, demonstrating that collaborative working can nourish relationships across the patient pathway, improve the services that are being delivered, improve outcomes for patients and deliver better value.

Networks enable integrated, multiprofessional, multidisciplinary care and the creation of integrated care pathways through a process of co-production between commissioners and providers of care, together with patients.

The breadth of conditions and the sheer number and variety of health professionals involved in delivering MSK care, in addition to the complexity and high level of comorbidity of many MSK conditions, mean that networks are particularly appropriate and important for delivering high-quality, coordinated and person-centred care in MSK, and significant – and sustainable improved outcomes.

The Health Foundation's Effective Networks for Improvement sets out the strong advantages for working across a network and the core features that make up an effective network.

The five core features of a successful network are:

- common purpose
- co-operative structure
- critical mass
- collective intelligence
- community building

These features are interdependent, and interact to give a network energy and momentum. They ensure a clear direction, credibility and increased scale and reach, while enhancing knowledge, encouraging innovation and creating meaningful relationships. All five features are mutually reinforcing and their combined effect enables quality improvement, learning and change to happen.

Importantly, one of the key lessons learned from the ARMA/ NHS England clinical networks project is that MSK service improvement initiatives are more likely to flounder if there is insufficient involvement and consultation with key stakeholders along the care pathway – this can result in unnecessary and avoidable costs being incurred. Networks can be a significant help in ensuring these potential pitfalls are avoided.

One of the key levers is to ensure clinical engagement and single clinical voice across commissioning and providing. This is essential for reducing clinical and operational risks. [Ian B.]

Through conducting patient and public engagement exercises, and involving relevant stakeholders, networks are more likely to be successful in identifying gaps in service provision, and developing and implementing appropriate and effective solutions. The Nuffield Trust recommends adopting the patient perspective as a key organising principle of service improvement, and in particular as a key means of achieving the

united clinical voice which is necessary for achieving genuinely integrated care.
[Reference: The Nuffield Trust *What is Integrated Care?* (2011)]

What can local MSK networks achieve?

A local MSK network can:

- **Commission services that address the needs of the population**
- **Define priorities** and draw up a workplan incorporating local, service user, and national priorities
- **Provide a forum to ensure that people with MSK conditions can inform the CCG of their experiences**
- **Improve and develop stakeholder relationships** – helping to bridge the gap between providers and commissioners, especially useful in a changing environment
- **Incorporate best practice** – network stakeholders can inform the network and provide a forum to resolve issues
- **Translate national policy and guidance into local action** – especially guidance and evidence from MSK national working groups and national and local care standards.
- **Improve services and reduce unwarranted variation** in access to MSK services – this will improve patient outcomes and cost-effectiveness of MSK services.
- **Improve data quality** – increase stakeholder contribution to relevant national MSK databases (eg; Hip Fracture database) and completing audits to inform workplans, service redesign, measure improvement through local dashboard creation.
- Work closely with those who are **responsible for commissioning GP services**.

Who should be involved in a local MSK network?

Local MSK networks should be made up of primary, community and specialist care, public health and local authority representatives, health commissioners and people with MSK conditions working in active partnership. The local MSK network will be a forum for leading the planning, provision, monitoring and quality improvement of effective MSK services at local level. It is the collaboration between the range of relevant stakeholders that provides the expertise and impetus for the development

of quality services as well as the links between different organisations, perspectives and disciplines to create a common vision.

Health practitioners delivering MSK care include:

Patients; GPs; specialist nurses; physiotherapists; chiropractors; osteopaths; podiatrists; occupational health therapists; orthopaedic surgeons; rheumatologists; chronic pain clinicians; psychological therapists; sports and exercise medicine clinicians; orthogeriatricians/ geriatricians; endocrinologists.

The key indicative stakeholders for a local MSK network are shown in the **MSK Network Team** diagram below, and the main responsibilities of each member are as follows:

1. Patient representatives – to provide experience of services and use this to inform improvement plans.
2. Care coordinators – inform the network of any system issues, service gaps and referral issues.
3. Primary and community care professionals – inform commissioners of any system issues, and training needs of primary care professionals, and provide expertise as and when required.
4. Consultants and Secondary care clinicians – provide clinical leadership to other stakeholders, across the main MSK clinical areas, and work closely with the network Chair/ Coordinator.
5. Allied Health Professionals – inform commissioners of any system issues, training needs of AHPs, and provide expertise as and when required.
6. Social care professionals – to inform the network of any system issues, and provide expertise as and when required.
7. CCG representatives – provide commissioning insight and gain knowledge from stakeholders to inform commissioning decisions.

8. Local authority/ HWB representatives – to ensure that MSK care is fully integrated with social care.

9. Public health representatives – has access to local health intelligence to inform commissioning decisions and service provision, as well as focusing on the prevention and broader public health agenda.



SECTION C

Ensuring the effectiveness of MSK networks

NHS England and CCGs have a key objective to improve service quality, and to support the development of local networks as a means of achieving this. Both published research and evidence gained through the ARMA/ NHS England MSK clinical networks project show that effective networks depend on at least three key elements: **effective leadership**; developing a **clear vision**; and having **clear priorities** for action.

Effective leadership

Effective leadership is a key requirement for any network. Influencing, negotiating, and developing relationships are vital to achieve objectives and to keep momentum forward to drive positive change. All network stakeholders have responsibility to maintain the network and the key leadership roles in the network should support them.

In addition to good leadership of the network, **patient representatives** are especially critical in MSK. They help to operate as the unifying principle around which the diverse voices of the many different health disciplines involved in MSK service provision operate. It is essential that MSK networks promote and help facilitate patient involvement, ensuring all decisions and plans are made in consultation and collaboration with people with MSK conditions.

Throughout the life of the network there will be an ongoing need to develop and engage other stakeholders as priorities develop and change overtime. Allowing this level of flexibility will ensure the success of the network and the network priorities.

Developing a clear vision for MSK service improvements

ARMA vision of excellent MSK services

- Delivers timely, integrated, **holistic patient-centred care**, tailored to the needs and wishes of the individual and delivered by skilled and appropriately trained healthcare practitioners
- Ensures **early intervention** via the accurate and speedy diagnosis of MSK conditions, with prompt referral for specialist treatment as appropriate
- Delivers **improved clinical and personal outcomes**, as defined by the patient
- Is **multidisciplinary in nature** and underpinned and informed by **shared decision-making**
- Delivers **coordinated care** via the provision of effective and personalised care planning
- **Empowers the patient** to self-manage and take control of their condition(s) via high-quality **information** and signposting to validated sources of additional support (eg charities)
- Maximises the opportunities for **community-based care and care closer to home**, including post-initial intervention
- Has excellent **communication channels** and links with and between all health providers and commissioners, patients and other interested professional and voluntary groups
- Has effective and accurate **monitoring systems** in place to enable quality care, and improvements to services, to be easily assessed and continually improved as necessary

Identifying priorities for action

Effective networks require a set of clear priorities.

Some priorities will depend on the needs and resources identified through the Joint Strategic Needs Assessment (JSNA) and the wider strategic priorities of local commissioners.

There is then a set of common national priorities which were identified through the ARMA/NHS England clinical networks project which local networks should consider.

The common national priorities emerged through an extensive consultation with patients (individuals, groups, and charities), MSK health professionals (including

consultant rheumatologists and orthopaedic surgeons, GPs, specialist nurses, physiotherapists, occupational therapists and other AHPs), managers and commissioners (CCG, regional and national), and MSK academic researchers.

Evidence shows^{xxvii} that local networks function most effectively if they are supported by an appropriate national framework (such as evidence-based guidelines), as well as being driven by a small energised, ‘hybrid’ leadership team, containing at least a mix of doctors, nurses and managers.

Following extensive consultation, the ARMA MSK clinical networks project identified four main priority areas where authoritative national guidance on “what good looks like” can be developed for local MSK networks, as well as commissioners and providers of care.

ARMA/NHS England MSK network priorities:

Integrated MSK services

Patients need to get the right treatment, in the right place and at the right time. To achieve this, MSK networks need to develop consistent evidence-based clinical pathways, looking at referral pathways and care pathways.

Creating multi-disciplinary teams (MDT) to operate a triage system involving secondary care clinicians helps provide coordination and continuity of care and ensure that patients see the right health professional(s) promptly, and therefore achieve the best patient outcomes. A high-quality MDT is more likely to pick up ‘red flags’, that are clinical indicators of possible serious underlying conditions which require further medical intervention.

Networks can also consider co-locating services, or holding services in alternative locations.

Networks can also look at developing an e-referral system, and also creating an integrated care record, which includes social and family support. Doing this means ‘yellow flags’ are more likely to be picked up. (Yellow flags are psychosocial

indicators suggesting increased risk of progression to long-term distress, disability and pain¹.)

Workforce: Education and Training

CCGs which have successfully developed integrated MSK services have found that, having identified 'pinchpoints' in the patient pathways, they have then had to identify more clearly what skills are required where, and work out who can best deliver the needed services.

For instance, in terms of improving care and referral patterns from GPs, networks may want to consider how they can best help to improve their own GPs' skillsets in MSK. Doing this effectively will mean that that accurate diagnosis and appropriate referral rates are improved, and increase GPs' confidence in dealing effectively with these very common conditions. (20% of GP consultations are for MSK conditions.)

Shared decision-making - involving patients in deciding on the best care for themselves – is another skill that networks may wish to ensure their MSK practitioners are equipped with. Resources for this are available from NHS England <http://www.england.nhs.uk/ourwork/pe/sdm>

Metrics

Using metrics and data effectively is a critical task for MSK networks working to improve MSK services.

Networks will initially want to develop tools to benchmark their local population against the general population in terms of MSK clinical needs, and this will help to write up the JSNA for MSK in the local area.

It will also be helpful for local networks to establish what metrics are being used to benchmark variations in care/ referral pathways; this will help to build the case for change. It will also help to establish the local priorities for service improvement, and also lead on identifying where the skills are to deliver the improved services.

Commissioning support units should be able to help assess whether a service is 'overheating' or not. It is crucial to establish where the inefficiencies are and how to use performance management to reduce unwarranted variation eg; where there

¹ Where this is the case MSK services need to consider referral to mental health and other appropriate local services

might be over- or under-referral from GPs. Establishing a threshold referral can be helpful in order to catch where there might be an unwarranted pattern of referral, which can then be followed up with appropriate support, such as peer support from a GP with a special interest in MSK.

A core principle for using metrics effectively is ensuring that everyone is using the same outcome indicators consistently, and that all are measuring the same thing. Clinicians should decide what the outcomes should be - and it is good to take something quite broad that can then be built on.

EQ5D has been used by some CCGs to measure and compare patient outcomes; ARUK has also led an expert group which has produced a set of new overarching indicators for MSK, as well as developing a patient outcome measure specifically for MSK conditions: the MSK Health Questionnaire.

Until the ARUK MSK Health Questionnaire is finalised, EQ5D may be chosen as an alternative; it is a standardised instrument for use as a health outcome measure, and is applicable to a wide range of health conditions and treatments. It provides a simple descriptive profile and a single index value for health status; it is primarily designed for self-completion by respondents, and takes only a few minutes to complete. For more information about EQ5D, visit www.euroqol.org

The National Clinical Audit for rheumatoid and early inflammatory arthritis which was published in January 2016 also provides useful data and metrics in relation to these condition areas in particular. For more information visit http://www.rheumatology.org.uk/resources/audits/national_ra_audit/default.aspx

Fracture Liaison Services

Fracture Liaison Services (FLS) successfully and cost-effectively case-find patients with fragility fractures who are at risk of osteoporosis. Implementing, or improving, a Fracture Liaison Service (FLS) has been identified as a potential 'quick win' for CCGs.

FLS systematically identify, treat and refer to appropriate services all eligible patients over 50 within a local population who have suffered fragility fractures, with the aim of reducing their risk of subsequent fractures. There is strong evidence from around the world that investment in FLSs results in improved quality of care, reduced costs and ultimately a more efficient and preventative model for the management of fractures.^{xxviii}

In 2009, a Department of Health economic evaluation of FLSs suggested that the potential saving to the NHS in England could be as much as £8.5 million over a 5-year period. This equates to approximately £290,708 per locality of 320,000.^{xxx} At present only 42% of health economies in the UK offer some form of FLS.^{xxx, xxxi} This figure presents an opportunity for clinicians and commissioners to improve care significantly and to realise savings through the development of effective fracture treatment, assessment and prevention services.

Further background information and details of resources available for those wishing to set up or improve their existing can be found in the Appendix.

Local Network Priorities

In addition to the above nationally identified priorities, local networks may also want to consider further local network priorities which are unique to their local health economy. These could be quick wins that are currently impacted at a local level, or larger priorities to achieve over a medium to long term. For example, embedding a public health approach to MSK might entail building relationships with the local authority and other service providers in order to have a wider approach to falls and fracture prevention, or to consider enhancing access to exercise and recreational facilities across the locality.

SECTION D

Commissioning

Commissioners need to commission services on the basis of population need. This requires a good needs assessment and the involvement of all key stakeholders. Ideally commissioners should commission for improved patient outcomes, and for a reduced burden of disability. 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.

Developing a local MSK network not only helps to ensure sustainable and effective improvements in MSK services are delivered, but also helps to avoid the potential pitfalls and dangers inherent in delivering change across complex health care systems. Where CCGs have tried to implement major changes quickly to their MSK

services, this has tended to result in costly and ineffective outcomes, both to service providers and to patients.

Networks help instead to incrementally build trust across the different MSK disciplines - and this leads to more effective and more sustainable service improvements than can be achieved by simply putting MSK services out to tender. The first task is to work out what works for your local area first - and only then consider how best to commission it. In this sense, contracts are subservient to patient need and not the other way round. (Sheffield CCG)

Most areas don't need to re-procure and shifting resources can be a painful and risky process. Working with those who are already involved in providing services is a less risky way to drive service improvement. [Ealing CCG]

Developing and working in partnerships allows for more flexibility around service improvements than competitive tendering - which has a poor record in bringing in sustainable service improvements.

It is important to note that developing a local MSK network does not necessarily lead to new commissioning arrangements. Once services have been improved, and only some years after this process was well underway, did several localities begin to commission MSK services based on outcomes rather than what some have called the 'perverse incentives' involved in Payment by Results.

The key message is that developing a local MSK network would both be the best way to ensure sustainable service improvement, and should also enable any commissioning model to be suitably designed which best suits the local healthcare economy.

Resources for Commissioning

Commissioning and contracting for integrated care. The King's Fund, November 2014
www.kingsfund.org.uk/sites/files/kf/kings-fund-commissioning-contracting-integrated-care-nov14.pdf

Beginning with the end in mind: how outcomes-based commissioning can help unlock the potential of community services NHS Confederation Briefing September 2014

www.nhsconfed.org/resources/2014/09/beginning-with-the-end-in-mind

CONCLUSION

There is much to do in terms of improving MSK services across NHS England, but it is clear what needs to be done, and who needs to be brought together in order to develop and implement sustainable, patient-centred, change. Effective local networks avoid both the possible and potential pitfalls of beginning the challenging but rewarding process of implementing sustainable MSK service changes which result in measurable improvements to patients with MSK conditions. There are already good examples of improved MSK services; the most successful of these have drawn on a networks approach in order not only to identify ‘what good looks like’ in their local area, but also crucially to get ‘good into practice’, working collaboratively across the diverse MSK disciplines, and putting the patient at the heart of the change process.

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