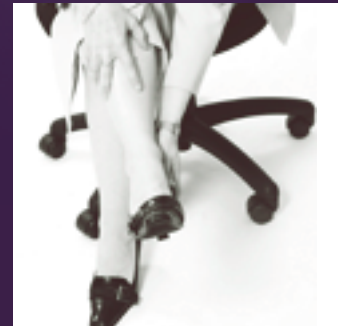




Standards of Care
for people with

Regional Musculoskeletal Pain



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ARMA is the umbrella organisation for the UK musculoskeletal community. ARMA is a registered charity No 1108851. Our member organisations are:

- Arthritis Care
- Arthritis Research Campaign
- BackCare
- British Chiropractic Association
- British Coalition of Heritable Disorders of Connective Tissue
- British Health Professionals in Rheumatology
- British Institute of Musculoskeletal Medicine
- British Orthopaedic Association
- British Osteopathic Association
- British Pain Society
- British Sjögren's Syndrome Association
- British Society for Paediatric and Adolescent Rheumatology
- British Society for Rheumatology
- British Society of Rehabilitation Medicine
- Chartered Society of Physiotherapy
- Children's Chronic Arthritis Association
- CHOICES for Families of Children with Arthritis
- College of Occupational Therapy Specialist Section – Rheumatology
- Early Rheumatoid Arthritis Network
- Lupus UK
- Manipulation Association of Chartered Physiotherapists (UK)
- Marfan Association (UK)
- National Ankylosing Spondylitis Society
- National Association for the Relief of Paget's Disease
- National Osteoporosis Society
- National Rheumatoid Arthritis Society
- Podiatry Rheumatic Care Association
- Primary Care Rheumatology Society
- Psoriatic Arthropathy Alliance
- Raynaud's and Scleroderma Association
- Rheumatoid Arthritis Surgical Society
- Royal College of Nursing Rheumatology Forum
- Scleroderma Society
- Society for Back Pain Research

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The contents of this document and further resources including contact details for our member organisations, further information about our work and this project, including additional examples of good practice and resources to support implementation, are available on the ARMA website at www.arma.net.uk.

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What is regional musculoskeletal pain?

Regional musculoskeletal pain can be defined as pain of short or long duration, localised to one body region, such as wrist, arm or knee. In these Standards regional musculoskeletal pain is distinguished from widespread pain, particularly chronic widespread pain which includes fibromyalgia. This distinction has been made because although there are some similarities in the risk factors, clinical features and treatments of regional and widespread pain, we believe that there are sufficient differences between them to merit individual attention, rather than doing both conditions a disservice by encompassing them within a single set of Standards.

Regional musculoskeletal pain: the size of the problem

Regional musculoskeletal pain is very common in the general population. By self-report, 10-30% of the population have had shoulder pain that lasted more than one week in the previous month, 5-10% report elbow pain and 5-15% report hand pain¹. About 10% of people have forearm pain at any one time². Even more report shoulder pain that lasted more than one day in the previous month³. Lower limb pain is equally common and may have a large impact on mobility. Up to 15% of people have disabling foot and ankle pain at any one time, and this is often associated with regional musculoskeletal pain elsewhere⁴.

What is the impact of regional musculoskeletal pain?

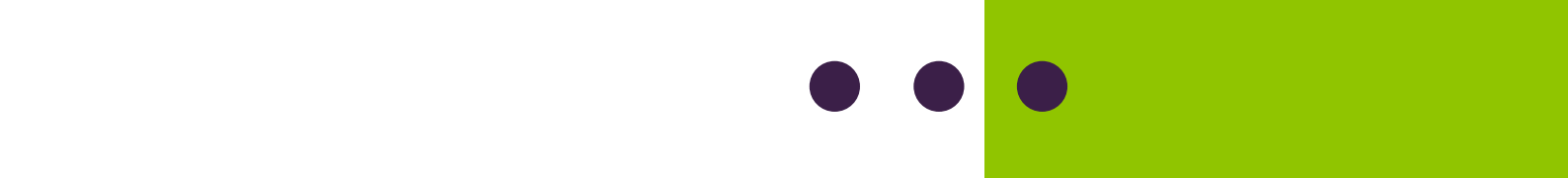
Musculoskeletal conditions are the single biggest cause of physical disability in the UK, and regional musculoskeletal pain constitutes an important component of this⁵. People with persistent or recurring regional musculoskeletal pain can have their lives significantly affected by their condition. It can reduce their quality of life, impacting on family and social relationships and limiting their capacity to work. Furthermore, the longer someone is absent from work with a musculoskeletal condition, the poorer their chances are of returning.

Risk factors for regional musculoskeletal pain

Both physical and psychosocial factors appear to be risk factors for regional musculoskeletal pain. The most important risks appear to be high levels of psychological distress, repetitive movements of the limb, undue forceful movements, monotonous work, and lack of autonomy at work^{6,7,8}. These factors may be related: regional musculoskeletal pain may be no more than an inconvenience until some other, unrelated life incident changes the situation from a person with a predicament into someone who sees a doctor with a pain, thus becoming a patient⁹. Addressing these factors may help reduce sickness absence due to regional musculoskeletal pain. Finally, recreational activity is considered an important contributor to the physical factors involved in the onset of these disorders, therefore advice may conflict with current initiatives to increase physical activity as a means of controlling obesity. Advice on how to exercise safely is one of the main features of these recommendations.

Prevention and treatment of regional musculoskeletal pain

Although a strong emphasis should be placed on prevention, surveillance is important with an active management approach. Raising awareness of regional musculoskeletal pain and the importance of prevention and early intervention will help reduce the prevalence of these disorders. Physical treatments have not been extensively evaluated. In established cases



management should be multidisciplinary taking a wider look at the problem and tackling both physical and psychosocial issues. It is worth noting that many aspects of this approach are shared with the treatment of other pain syndromes such as neck and low back pain.

Why we need Standards of Care

Evidence shows that people's experiences and the quality of care they receive varies a great deal across the UK, depending on the approach and configuration of their local services. The care of people with regional musculoskeletal pain requires self-management with the input of a range of health professionals and others in voluntary and public sector support roles, such as advice and employment services.

There is good evidence for the effectiveness of many interventions and treatments. Furthermore, many services are delivering innovative and successful management of regional musculoskeletal pain, but to date there has been no agreed common standard of how this can be best achieved.

For many years musculoskeletal conditions have not featured significantly in major health policies across the UK: The National Service Framework for long-term conditions in England mainly focuses on neurological conditions, and no musculoskeletal conditions feature in the Quality and Outcomes Framework of the current UK General Medical Services Contract. This has led to a lack of profile and priority for musculoskeletal conditions in the delivery of services.

The public policy agenda is better now for musculoskeletal conditions than when ARMA first published Standards of Care in 2004. Recently there have been a number of policies published which have implications for musculoskeletal services. The publication of the *Our Health, Our Care, Our Say* White Paper in January 2006 outlined some important aims: better prevention services with earlier interventions; more choice and a louder voice; tackling inequalities and improving access to community services; and more support for people with long-term needs. These are also fundamental principles within the Standards of Care.

In addition the development of the Musculoskeletal Services Framework for England, a Welsh Arthritis Strategy and the ICATs scheme in Northern Ireland are welcome policy initiatives that will help service providers and commissioners achieve the ARMA Standards of Care. People with regional musculoskeletal pain are also likely to be affected by other areas of policy, such as the recommendations of the Welfare Reform Bill, which places a heavy emphasis on supporting people back into work.

These Standards of Care aim to bring together existing evidence and good practice to create a framework for services which truly meet the needs of the many people who experience regional musculoskeletal pain. Implementation of these Standards should:

- Improve prevention and effective treatment of regional musculoskeletal pain and so improve the quality of life of individuals who are affected by regional musculoskeletal pain
- Identify for people with regional musculoskeletal pain the care and treatment they can expect
- Enable the NHS to make more effective use of resources by helping prevent avoidable disability and by reducing the number of return GP consultations and hospital appointments due to regional musculoskeletal pain

- Promote consistent advice and treatment
- Reduce levels of disability due to regional musculoskeletal pain
- Improve productivity and reduce the cost of benefits by enabling people to stay in work.

-
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ARMA's Standards of Care for people with regional musculoskeletal pain are intended to support people of all ages with regional musculoskeletal pain to lead independent lives and reach their full health potential through:

- access to information, support and knowledge that optimise musculoskeletal health for everyone and enable self-management
- access to the right services that enable early diagnosis and treatment
- access to ongoing and responsive treatment and support.

The Standards define what services are appropriate under these three themes and suggest ways of providing them effectively, and in a measurable way, in the form of key interventions. A detailed rationale for the Standards draws on available evidence and examples of good practice drawn from ARMA's ongoing call for good practice: a database giving details of these and other examples is available at www.arma.uk.net.

The Standards are not guidelines or algorithms of care, though they refer to these where available. The Standards of Care for people with regional musculoskeletal pain form part of a suite of Standards; other Standards published to date are for back pain, connective tissue diseases, inflammatory arthritis, metabolic bone disease and osteoarthritis.

The Standards acknowledge the fact that those planning and delivering services around the UK face differing demographic, geographic and economic factors, which will affect how the Standards are implemented in each locality. We hope the Standards will act as a tool for all stakeholders - service users, providers, commissioners and policy-makers - to work together to review and improve their local musculoskeletal services.

Key principles – the user-centred approach

The project has been driven by the needs of people living with musculoskeletal conditions. It began with the establishment of a set of key principles for care, developed by a group of people living with musculoskeletal conditions and consulted upon widely. These principles have underpinned the development of each set of condition-specific Standards. The key principles, which can be found on ARMA's website www.arma.uk.net, affirm that 'patients' are individuals who need different types of advice and support at different times; and who need integrated services providing advice and support that cover all aspects of managing and living with the condition – clinical, personal, social and employment/education. In particular, the Standards recognise that health services play a key role in supporting people to maintain or return to employment or education.

Nevertheless, while these standards focus on health services, it must be recognised that people with regional musculoskeletal and other musculoskeletal conditions have wide-ranging needs. Social care often plays a key role in ensuring people can remain as active and independent as possible. Factors such as access to transport and the built environment may have a major impact on quality of life. More work is needed to understand and meet these needs.

Musculoskeletal conditions affect families and carers as well as individuals. Indeed, many people with these conditions may be carers themselves. The Standards do not make specific recommendations on issues relating to carers: this also needs to be the subject of further work to ensure that carers' needs are understood and addressed.

How the Standards were developed

The Standards of Care for people with regional musculoskeletal pain were developed by an expert working group, facilitated by ARMA. The group included experienced service providers and experts from many professions from around the UK. Starting with a review of the needs of people with regional musculoskeletal pain, the group met 3 times between November 2005 and July 2006 to determine evidence-based Standards to meet those needs, consulting widely and publicly on the drafts. The Acknowledgements on page 19 give details of the working group membership.

Clinical experts have identified the evidence base, including relevant guidelines for the management of regional musculoskeletal pain. References are shown as end notes in the Standards. Evidence has not been graded for the purposes of this document. For further details on the evidence base, please refer to the references quoted in the document.

The resulting Standards are therefore based firmly on the experiences and preferences of people with regional musculoskeletal pain, and on evidence and good practice where this is available. ARMA plans to review these Standards in 2009, or sooner if there are significant developments in care for people with regional musculoskeletal pain.

Next steps

The publication of these Standards is the beginning of an ongoing programme involving the whole community to improve musculoskeletal services. We are circulating the Standards widely to people with musculoskeletal conditions, doctors, allied health practitioners, providers and commissioners of health services, voluntary organisations and policy makers. We will publish audit tools to support the Standards' implementation. We are also collecting and sharing examples of good practice, which are accessible to everyone through our online database.

We invite all stakeholders to make a commitment to implementing the Standards. First steps might be to:

- audit existing services
- identify champions for change in musculoskeletal services, and set up a working group to develop your local strategy and priorities
- work in partnership with all stakeholders, including national and local voluntary organisations, to involve service users in designing and developing services.

Above all share your success! Tell us about your initiatives; send us examples of good practice; help to build a national resource for high-quality musculoskeletal services.

Promoting musculoskeletal health

Standard 1

Health, community and education services should make information available to the public (in a range of languages and formats) on lifestyle choices that promote good musculoskeletal health. This should be evidence based, of consistent quality and include information on self-management, physical activity and exercise, diet and nutrition and the prevention of injuries, including occupational, leisure and sports injuries. It should be available in many settings including the workplace, leisure facilities, pharmacists, primary and secondary care services, schools and centres of further education and complementary practitioners specialising in musculoskeletal health.

Information on self-management and prevention

Standard 2

Health and community services, employers, the voluntary sector and other agencies, including public and privately run leisure facilities should provide information through a range of media.

They should offer advice and support to help people:

- identify factors which lead to regional musculoskeletal pain
- identify symptoms of regional musculoskeletal pain
- manage their pain
- remain active
- know when to seek professional advice
- prevent recurrence

NHS Direct information and advice should be expanded to better cover regional musculoskeletal pain and its prevention and management.

Information on services, treatments and providers

Standard 3

People with regional musculoskeletal pain should have access to information and guidance (in a range of languages and formats) that enables them to make an informed choice from a range of service providers, the treatments they offer, the facilities in which they are delivered and their relative costs.

The rationale

- Many people will experience regional musculoskeletal pain during their lives and for most this will be short-lived. Most individuals should be able to manage their pain without needing medical advice¹⁰.
- People with regional musculoskeletal pain should be regarded as equal and active partners in their healthcare. For this to happen they need to be well-informed about their condition, empowered to take responsibility for their musculoskeletal health, and able to make informed choices about service providers, care settings and treatments¹¹.
- People are not always aware of how to reduce the risk of developing regional musculoskeletal pain^{12,13}. Information should be widely available which is evidence-based and emphasises a safe approach to physical fitness and weight reduction and encourages the adoption of a healthy lifestyle¹⁴.
- Health promotion campaigns have been shown to be effective in promoting messages about maintaining musculoskeletal health¹⁵. Campaigns should inform people how to identify

persistent symptoms which they should report to appropriate health care professionals. These messages are likely to have the greatest impact when they are positively promoted by everyone involved or interested in the problem of regional musculoskeletal pain, including employers, education and health service providers, leisure services and voluntary organisations.

- While many people at present visit their GP to report symptoms and gain advice and treatment, the GP should not be regarded as the only point of contact with the health service. Pharmacists and other healthcare professionals in primary care and/or the workplace may also be able to offer detailed advice and management. Making people aware of the risk factors and early symptoms has been shown to reduce the incidence of musculoskeletal pain in the workplace.
- Confusion exists about the need to limit physical activities during an episode of regional musculoskeletal pain, for example about the need for absence from work. Health promotion programmes should also educate people to avoid unnecessary inactivity and to maintain normal activities.
- People with regional musculoskeletal pain should be involved in helping to plan and develop services at both a local and national level¹⁶. Their perspective on service delivery can lead to imaginative solutions and improvements to healthcare services and to reductions in the incidence of pain.
- Recognition that regional musculoskeletal pain can affect any age group – including children and adolescents.

Good Practice Example - A **Strategic approach to the management of musculoskeletal disorders within the UK division of a large international food manufacturer**

A corporation with 8,000 employees has developed specialised occupational health and safety policies after recognising that musculoskeletal problems are the single biggest cause of accidents and work-related illness.

The policies aim to avoid manual handling operations where there is risk of injury, and give all employees manual handling training appropriate to their job where manual handling cannot be avoided. Onsite physiotherapy allows employees to access advice and services quickly and all staff receive education and training to prevent injury, report problems early and ensure swift intervention when employees require treatment and rehabilitation. A central occupational health helpdesk and corporate intranet site provide information and advice. A team of occupational health nurse advisors and consultant physicians with designated areas of responsibility are involved in planning and assessing the services.

The corporation's policies and their implementation led to a reduction in work-related upper limb disorders from 59 in 1996 to just 5 in 2005, and a reduction of musculoskeletal cases among employees from 577 to 57 in the same period.

Putting the Standards into practice: key interventions

- i There should be coordinated public health strategies that bring together a range of government departments to promote good musculoskeletal health.
- ii Health promotion strategies should encourage and educate people about how to self-manage episodes of regional musculoskeletal pain¹⁷.
- iii Workplaces, leisure facilities, pharmacists, primary and secondary care services, schools and centres of further education, and manual therapists should provide information on how to manage episodes of regional musculoskeletal pain¹⁸. This information should be of consistent quality and should be freely available.
- iv Information should be clear, accessible and available in a variety of formats and languages. Professionals involved in caring for people with regional musculoskeletal pain should take into account their language, culture, educational level and disability.
- v There should be information on the facilities available for physical activity and exercise in the community.
- vi Employers should be encouraged to access information about managing regional musculoskeletal pain in the workplace in order to promote good working practices, e.g., providing occupational health services and forming links with government-supported rehabilitation services¹⁹.
- vii New comprehensive algorithms for regional musculoskeletal pain should be developed for use by NHS Direct staff.
- viii People who have experienced episodes of regional musculoskeletal pain, and voluntary organisations concerned with their care, should be involved in and consulted about the development of health care policy and practice at both a national and local level.

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Access to diagnosis

Standard 4

Health professionals in primary care should be well-trained and informed about regional musculoskeletal pain and the local facilities available for treating it.

Standard 5

Health professionals in primary care should have timely local access to diagnostic and other services. They should be able to refer individuals appropriately, either directly for investigations, further opinion or other support. Primary care services should be accessible at times and locations that are appropriate to the needs of service users.

Standard 6

Local services provided by the NHS, manual therapists, and other services should have good communication links to ensure that patients are managed appropriately. Patients should be offered the option of receiving copies of correspondence between services regarding their management.

Assessment of needs

Standard 7

On presentation, people should have a full assessment of their condition (and subsequently, where necessary, imaging, biomechanical and ergonomic assessments), general health, workplace, psychosocial and pain management needs. These assessments should consider referrals or communication (with appropriate consent) with other services and organisations e.g. JobCentre Plus, occupational health teams, social, leisure and education services. For children and young people, specific attention should be paid to their educational needs and physical activity.

Parents and carers should be involved in all discussions where appropriate.

After consultation people should be given an appropriate explanation of their condition at the time and information in paper format for them to read after the consultation. They should also have access to someone they can ask general questions about their condition. Further, authoritative, accessible on-line electronic information should be available through NHS Direct. This should be comprehensive, reliable, and up-to-date, as well as interactive and easy to use.

Individualised care plans

Standard 8

On diagnosis, people should be offered an appropriate individualised plan for ongoing care. This should give constructive messages about their condition and the roles for the patient and the multidisciplinary team and other relevant parties, e.g. employers, in the management of their condition. This care plan should draw on good clinical practice and be evidence-based. The health practitioner should work with the service user to identify possible triggers or causes of their condition and to build joint solutions for the monitoring and management of their condition.

Pain relief

Standard 9

People with regional musculoskeletal pain should be offered pain management strategies and where necessary, symptomatic pain relief. These should be in accordance with the best available evidence and national guidelines. With children and adolescents, if regional pain is persistent, further paediatric advice should be sought for appropriate pain relief strategy.

Support to remain in, or return to, work, education or the home environment

Standard 10

People with regional musculoskeletal pain should be encouraged to remain active and mobile as far as possible and be supported to remain in or return to education, work (paid or unpaid) or their own home. They should have access to information and support from rehabilitation services and wider information about how to access services beyond the health service, e.g. *JobCentre Plus*.

Rehabilitation services should work with people who have regional musculoskeletal pain and their employers or educational institutions to support them to stay in work or education and build solutions to prevent a continuation or recurrence of their condition.

Standard 11

People with regional musculoskeletal pain whose condition restricts their ability to work or carry out their normal caring and social

responsibilities should have access to someone who can advise them on the financial and other support services available. This advice should take account of their language, culture and educational level.

Involvement of people with regional musculoskeletal pain in service development

Standard 12

Healthcare organisations should involve people with regional musculoskeletal pain in the planning and development of services for this and other musculoskeletal conditions.

The multidisciplinary team

Standard 13

People with persistent or worsening pain should have timely access to appropriate members of the local multidisciplinary team, appropriate to their age who should have had training in the management of musculoskeletal conditions including regional musculoskeletal pain.

The rationale

- Regional musculoskeletal pain, particularly when persistent, leads to loss of productivity²⁰ and diminishes quality of life. It is vital to try to prevent recent onset of regional musculoskeletal pain from developing into a chronic health problem. Primary care musculoskeletal pain research has identified a 'window of opportunity' in the appropriate and timely management of pain and disability^{21,22,23,24,25}. It is therefore crucial that people whose pain is not responding to self-management are able to get timely and reliable advice and management to restore them to optimal health as quickly as possible^{26,27}.
- Most regional musculoskeletal pain can and should be managed in the community.
- The development of protocols that enable health professionals to refer people with regional musculoskeletal pain appropriately for investigations, further opinion or other support, should help to minimise delays in their assessment and management.
- A very small percentage of people will have warning signs which need to be investigated. Health professionals should screen people for these warning signs or 'red flags', which may indicate serious disease. People in whom serious disease is suspected should be considered for referral without delay to specialist services for investigation and treatment using the following existing guidelines for the assessment of regional musculoskeletal pain.

- Other ‘flags’ may be of use in identifying risk factors for regional musculoskeletal pain in the workplace. These include physical factors associated with the development of musculoskeletal pain and other workplace factors which are associated with the onset of symptoms (‘blue’ and ‘black’ flags). Further, psychological factors may influence the onset of symptoms. Screening tools are available²⁸. All of these are important and should be viewed as obstacles to recovery, so that just treating the symptoms may not solve the problem.
- All people with regional musculoskeletal pain require information to enable them to make informed choices about the range of management options available, including self-management. All professionals involved in the care of people with regional musculoskeletal pain should encourage and support them to remain active, to continue at work or in education wherever possible and maintain other normal activities³⁰.
- Expert opinion suggests that adequate pain control is an essential option in order to allow reactivation and prevent the development of chronic pain states³¹. Some people require analgesics to control their pain. These should be appropriate and adequate and may initially include short-term opioid use if the pain is severe.
- Latest evidence and current thinking support the use of biopsychosocial assessment and intervention in or near the workplace/educational establishment for improved early management of musculoskeletal disorders, including regional pain syndromes^{32,33}.

Flags

1. Identify ‘red flags’ i.e. items that may suggest alternative diagnoses or referral for further investigation and/or management:
 - joint swelling
 - signs of infection: swelling, heat and redness of the painful area
 - vascular changes
 - systemic symptoms: weight loss, fever
 - severe constant unremitting pain unresponsive to analgesics
 - growth abnormalities in children
2. Identify physical factors which are important risk factors for some of these disorders:
 - high rates of repetition
 - prolonged abnormal postures
 - high force requirement
3. Identify ‘flags’ which are important as risk factors and are obstacles to recovery:
 - ‘Yellow flags’ (psychological)
 - maladaptive illness beliefs (for example catastrophising, fear avoidance)
 - depression or psychological distress (screening tools are available)
 - ‘Blue flags’ (workplace issues)
 - monotony
 - low degree of control
 - poor relationships
 - high work demands
 - ‘Black flags’ (workplace organisational issues)
 - financial reliance on disability benefits or workers’ compensation issues
 - surveillance and attitudes to sick worker

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Good Practice Example - B Musculoskeletal interface service

A primary-care based musculoskeletal interface service brings together extended scope physiotherapists, clinical nurse practitioners, consultants in pain management and a development lead, supported by orthopaedic consultants, to provide assessment and management services for people with regional musculoskeletal pain and other musculoskeletal conditions.

This service set up care pathways to prevent those patients who can effectively be managed in primary care from being inappropriately referred to orthopaedic surgeons. This reconfiguration has reduced cost per episode of treatment substantially, and waiting times have dropped from 21 weeks to 4 weeks for a specialist opinion. The wait for MRI scans has dropped from 12 months to 2 weeks, and pressure on orthopaedics has been eased, with 75% of those referred to orthopaedics actually requiring surgery.

Putting the Standards into practice: key interventions

- ix There need to be skilled practitioners at the first point of contact who can:
 - perform an accurate assessment using standard instruments to determine signs of suspected serious disease or injury that requires specialist opinion and investigation
 - refer people directly to specialist services, to be seen according to clinical urgency, if they identify warning signs of serious disease, risk factors for recurrence and obstacles for recovery or yellow or red flags
 - offer effective pain management in accordance with national guidelines
 - offer an initial explanation of the condition and preliminary advice
- x Clinical governance teams and service commissioners should ensure that there is access to continuing professional development about the needs and care of people with regional musculoskeletal pain for all those involved in their care and support.
- xi Problems that are not resolved in a short period of time, e.g. four weeks, should be referred onto a specialist practitioner in line with the evidence base³⁴.
- xii In a primary care setting, if investigations are desirable they should be performed and reported within one week of request. Other complex investigations, for example MRI scanning, should be performed and reported within one month of request, depending on clinical urgency.
- xiii Following diagnosis, people should have access to information on the steps that can be taken to secure support. Advice should be available on modifying working practices and on adapting workplaces and educational establishments. Employers should seek advice from various sources, for example from health professionals and government agencies, including the Health and Safety Executive (HSE) and JobCentre Plus Advisors, for example Access to Work and Disability Employment Advisors.
- xiv Specific care pathways for the individual affected, employers and health professionals should be developed where appropriate. These must be interlinked in order to maximise opportunities for people to remain in work or education and stay active.

Good Practice Example - C

Development of a physiotherapy service for NHS staff

An occupational health department for NHS staff has invested in a physiotherapist with advanced ergonomic skills to help prevent and manage musculoskeletal problems in the workforce. This self-referral system into physiotherapy allows staff members with musculoskeletal conditions to access quality advice to help them continue working and avoid unnecessary absenteeism.

Staff can access the specially trained senior physiotherapist within two days by contacting the physiotherapy department directly. This quick access has resulted in faster returns to work and improved ability to stay in work for those staff members with a musculoskeletal condition. The service supports 4,500 staff members and is audited annually through staff questionnaires.

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Self-management

Standard 14

People with persistent regional musculoskeletal pain should receive ongoing information about their important role in managing their condition, and be supported to make the necessary lifestyle changes e.g. occupation, leisure and other contributory factors to improve their health.

The rationale

- Regional musculoskeletal pain services will often be provided by an extended scope practitioner. To minimise delay in assessment and management, this professional should be able to refer people directly for investigations, further opinion or other support.
- Self-management programmes are beneficial and often preferred by people with long-term conditions such as regional musculoskeletal pain^{35,36}.
- People with persistent pain that is not responding to treatment may benefit from other types of management, including psychosocial support, cognitive behavioural therapy and other pain management strategies³⁷. It is important that they can access these services rapidly^{38,39}, at least within eight weeks. All treatments should be evidence-based.
- The longer a person is off work with regional musculoskeletal pain, the less likely they are to return^{40,41}. People with regional musculoskeletal pain should be encouraged to remain at work or in education, or return as soon as possible as this has been shown to improve recovery. Furthermore, by definition, the longer a person has had regional musculoskeletal pain, the more likely they are to have a chronic pain syndrome which may result in widespread musculoskeletal pain^{42,43}. Therefore, it is essential that their pain is recognised and treated as quickly as possible. Those people that are unable to return to work may need advice and support to access benefits and other services.

Putting the Standards into practice: key interventions

- xv If serious disease (see red flags) is or becomes apparent, immediate referral should be made to appropriate specialist services.
- xvi There should be prompt access to a triaging service for people with regional musculoskeletal pain where conservative management has not been successful. Triage arrangements should have been agreed with the relevant stakeholders including:
 - provider services (pain, orthopaedic, rheumatology, paediatrics, therapy)
 - commissioners of services
 - user groups.

- xvii A comprehensive chronic pain service should be available to include psychosocial support, counselling, psychology, cognitive behavioural therapy, pain clinics and full Pain Management Programmes (PMPs).
- xviii People should have access to self-management and education programmes, including the Expert Patient Programme.
- xix Clear and consistent information should be available about evidence-based treatment options, providers and services, including local and national support groups. This should be available in a variety of formats, in accessible and understandable terms, and in different languages where appropriate.
- xx In instances where people need surgery, they should have prompt access to a specialist surgical service. They should be offered an opinion from a specialist surgeon within three months of referral or sooner if clinically indicated.
- xxi The small number of people who need surgery should be given information to help them to make a decision about whether to have surgery and to support them in preparing for and recovering from surgery. Pre-operative assessment and discharge planning should involve all professionals involved in their care.
- xxii People should have access to services to support them in remaining in or returning to work or education. These could include physical rehabilitation services, vocational rehabilitation and/or occupational health services, Access to Work Advisors and Employment Medical Advisory Services, who are able to work in liaison with employers and individuals.
- xxiii People should have access to a case manager with expertise in employment issues, who can help to 'bridge the gap' between people's health and employment needs.

Good Practice Example - D **Developing community support for physiotherapy patients**

A health services trust has employed two key workers to support people leaving physiotherapy or pain management services, after patients identified a lack of community follow-up support.

The return to work advisor provides information and support on benefits, career and education opportunities, CV-writing and signposting to other services. This key worker can also accompany clients to relevant appointments.

The fitness advisor works with people with regional musculoskeletal pain to develop personal training programmes and accompanies people to community exercise activities of their choice. This key worker also runs a 6-week exercise session in a community setting and trains other community fitness instructors in appropriate exercise for people with regional musculoskeletal pain.

- xxiv People should have ongoing access to careers advice, employment advice and job retraining which addresses their individual case.
- xxv Children and young people should be supported by all people responsible for their care (including doctors, allied health professionals, teachers, social workers, youth workers and others) in achieving their normal social, educational and physical milestones.
- xxvi People should have access to advisory services for benefits and other appropriate support if they are unable to work.

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Allied Health Professional (AHP)

a person who offers advice and clinical care who is not necessarily medically qualified. For example, this would include a nurse, pharmacist, physiotherapist, occupational therapist and podiatrist. These healthcare professionals are registered with and regulated by the Health Professions Council. Other healthcare professionals, such as manual therapists (osteopaths and chiropractors) should also be qualified and registered with their own professional body.

biomechanical

some health professionals look at the body as a machine. They use mechanical theories applied to the limbs and joints to try and explain the causes and consequences of injuries. This is called a biomechanical assessment.

biopsychosocial

the biopsychosocial model stresses the importance of a holistic approach to treatment by considering factors outside the biological process of a condition. In this approach, a person's social context and psychological wellbeing are key factors, along with their thoughts, beliefs and emotions.

cognitive behavioural therapy

a combination of cognitive therapy, which can modify or eliminate unwanted thoughts and beliefs, and behavioural therapy, which can help to change behaviour in response to those thoughts⁴⁴.

conservative management

management to reduce the impact of illness without using invasive or high-risk measures

episode

a period of time during which someone experiences regional musculoskeletal pain.

ergonomic

an ergonomist looks at the way people interact with their environment, at home, during sport or at work. An ergonomic assessment of a typist, for example, would look at the seating and posture, the keyboard position and the height of the display screen. An ergonomist would make recommendations based on this assessment which may include, for example, changing the working posture. Even the job itself might be appropriate for consideration: could it be done in a different way or by a machine, for example?

extended scope practitioner

a health professional with additional skills and clinical responsibilities.

Expert Patient Programme

the name given to an initiative to help people with long-term conditions maintain their health and improve their quality of life. A key element of this initiative is lay-led self-management training whose primary aim is to facilitate the development of self-management skills rather than to provide medical information.

healthcare professional

a person who offers advice and clinical care who is not necessarily medically qualified. For example, this would include a nurse, pharmacist, physiotherapist, occupational therapist and podiatrist. These healthcare professionals are registered with, and regulated by the Health Professions Council. Other healthcare professionals, such as manual therapists (osteopaths and chiropractors) should also be qualified and registered with their own professional body.

ICATs

integrated Clinical Assessment and Treatment Services – a way of organising services that is designed to ensure that people referred by GPs are assessed by teams and further referrals to hospital consultants are provided only where necessary.

interventions

a general term covering treatments, advice, education and other care that a practitioner may give.

MRI scanning

a machine that takes 3D pictures of the body, using a powerful magnet as opposed to X-rays. Very good images of the soft tissues are obtained - an advantage over X-rays which are best at showing bone. Because of the powerful magnets people who have pacemakers, artificial heart valves and other embedded metallic materials should not undergo MRI scans.

multidisciplinary team

a healthcare team that includes professionals from different disciplines working together to provide a comprehensive service for people with regional musculoskeletal pain. The team may include physicians, doctors in training (both hospital and GPs), GPs with a special interest in rheumatology (GPwSI), nurse specialists, physiotherapists, occupational therapists, dieticians, podiatrists, orthotists, psychologists, pharmacists and social workers.

persistent pain

pain that has lasted for more than three months or has been present in episodes on more than half the days of the previous year; sometimes alternatively referred to as chronic pain.

primary care

care services available in the community, for example through a community pharmacist or the care provided by a GP. This is often a person's first point of contact for advice, information and treatment.

psychosocial support

professional care which addresses a person's psychological and social health needs. This may include support to reduce a person's distress, fear or ability to cope, support for social and family relationships, and support/advice about employment or benefits.

red flags

a group of symptoms or signs (clinical indicators), any one or more of which may suggest a possibility of serious disease.

secondary care

care available usually in a hospital setting. People generally need referral from a professional in primary care.

triage

the categorisation of a person's regional musculoskeletal pain in order to decide the preferred treatment options and or/referral pathway.

vocational rehabilitation

helping people get back to work by focusing their treatment and rehabilitation on the requirements within their job, whether it is manual or office based. Some vocational rehabilitation schemes will create an artificial workplace environment in order to work towards getting people back to work. This helps them concentrate on doing certain aspects of their job without the pressure that is sometimes felt within the actual work environment.

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Standards of Care
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