



Musculoskeletal core offer for Local NHS plans

The impact of musculoskeletal ill-health on individuals, NHS and the economy is widely recognised including in the NHS Long Term Plan: “Longer-term health conditions also make an increasing contribution to the overall burden of disease. Mental health, respiratory and musculoskeletal conditions are responsible for a substantial amount of poor health and place a substantial burden on the NHS and other care services.”

Effectively addressing musculoskeletal conditions will therefore be important in delivering on the ambition of the long-term plan. This document aims to help those developing local plans to understand the core offer needed to deliver evidence based, cost effective services for good MSK population health, and to signpost towards information and support available to help those looking to improve services.

The document sets out a core offer in five areas:

- Underpinning framework
- Services
- Prevention
- Mental Health
- Personalisation

1. Underpinning framework

Effective MSK services depend on an underpinning framework of integration. Integrated Care Services and Primary Care Networks should ensure that this is in place for MSK. “An ICS brings together local organisations to redesign care and improve population health, creating shared leadership and action. They are a pragmatic and practical way of delivering the ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care.”

Requirement	Long term plan	Support and further information
<p>Understanding of local need. Shared leadership to improve population health requires shared understanding of local need. To achieve this, MSK should be included in the local Joint Strategic Needs Assessment so that all system partners share the same understanding. Involving people with MSK conditions in designing services and pathways will help ensure they meet local need.</p>	<p>“Local NHS organisations will increasingly focus on population health”</p>	<p>PHE MSK diseases profile provides data by local area. https://fingertips.phe.org.uk/profile/msk NHS RightCare MSK Focus Pack</p> <p>Versus Arthritis MSK Calculator provides data on hip and knee OA, back pain and RA by local area.</p> <p>Webinar on developing and using an MSK chapter in a JSNA</p> <p>Global burden of disease data is provided at national regional and local level.</p>
<p>Workforce. People with MSK conditions usually need a range of interventions such as manual therapy, exercise-based services, self-management support, etc. This can only be provided effectively if there is a multidisciplinary team available in the community. The high incidence of people with MSK conditions having multiple other long-term conditions makes a multi-disciplinary approach doubly important.</p>	<p>“Expanded neighbourhood teams will comprise a range of staff such as GPs, pharmacists, district nurses, community geriatricians, dementia workers and AHPs such as physiotherapists and podiatrists/chiropractors, joined by social care and the voluntary sector.”</p>	<p>Given the workforce challenges faced by primary and community care, effective and appropriate use of the full range of professionals with knowledge of MSK conditions including physiotherapists, chiropractors, osteopaths, dieticians, podiatrists, sport therapists, sport and exercise physicians, pharmacists, acupuncturists, occupational therapists, specialist nurses, GPs, geriatricians.</p>
<p>Pathways. Local MSK services should be organised and commissioned in pathways, including pain medicine, orthopaedics, rheumatology and hospital/community therapy services, enabling patients to be rapidly directed to the appropriate point on</p>	<p>“The NHS will increasingly be: more joined-up and coordinated in its care. Breaking down traditional barriers between care institutions, teams and funding streams so as to support the increasing number of people with long-term health conditions,</p>	<p>Resources and implementation kit for National Back and Radicular Pain Pathway</p>

<p>the pathway. All the services listed below need to be available to patients who need them in a seamless way. This means that everyone who acts as a first point of contact for patients should understand how these interventions are provided and referral routes.</p> <p>Back Pain Pathway. The Pathway is demonstrating improved clinical results in patient clinical outcomes and patient satisfaction and the national roll-out is being supported by NHS RightCare. The National Back and Radicular Pain Pathway should be implemented.</p>	<p>rather than viewing each encounter with the health service as a single, unconnected ‘episode’ of care;”</p>	
<p>Community based prevention end of pathway. Providing access to the interventions listed under prevention is often poor, either because they do not exist, or because they exist in the community, disconnected from clinicians who are the first point of contact with patients. Primary Care Networks should ensure that the interventions are commissioned and integrated into the pathway.</p>	<p>“2.7. The role of the NHS includes secondary prevention, by detecting disease early, preventing deterioration of health and reducing symptoms to improve quality of life. Every 24 hours, the NHS comes into contact with over a million people at moments in their lives that bring home the personal impact of ill health. This Long Term Plan sets out practical action to do more to use these contacts as positive opportunities to help people improve their health. This will contribute to the government’s ambition of five years of extra healthy life expectancy by 2035.”</p>	<p>See below for prevention interventions. These should be integrated into local pathways, not commissioned in isolation.</p>
<p>Links into specialist care end of pathway. There is a significant issue with access to rheumatology, with the average time for diagnosis of, for instance, Axial</p>	<p>“3.49. Longer-term health conditions also make an increasing contribution to the overall burden of disease. Mental health, respiratory and musculoskeletal conditions</p>	<p>A list of the key resources early identification in primary care</p> <p>Commissioning for Quality in Rheumatoid</p>

<p>Spondyloarthritis, being 8 years. Primary Care Networks needs to ensure good join up with secondary care rheumatology services and ensure that primary care staff are able to identify potential inflammatory, or autoimmune MSK or hypermobility-related conditions which need rapid onward referral.</p>	<p>are responsible for a substantial amount of poor health, and place a substantial burden on the NHS and other care services.”</p>	<p>Arthritis resources</p>
<p>Health and Work. For most people with an MSK condition, good work is beneficial to health. All clinicians should discuss work with patients and the fit note should be used as a tool to enable people to return to work with adjustments.</p>	<p>“For people in work, fast and convenient access to health services plays an important role in maintaining employment. Mental health and musculoskeletal conditions remain the main reason for sickness absence. NHS provision of services for both is increasing.”</p> <p>“People who are off work for more than four weeks are more likely to fall out of work permanently. Personalised care plans that support people to manage their condition in work, with reasonable adjustments where needed, will reduce this.”</p>	

2. Services

The following MSK services should be available to everyone who needs them, easily accessible without long waits, through an effective integrated pathway.

Everyone who needs it should have access, without undue waiting times, to:	Long term plan	Support and further information
<p>A First contact MSK practitioner (FCP). The FCP role can be provided by anyone who meets the capabilities set out in the FCP framework. NHS England are currently supporting a programme to roll this out across every STP.</p>	<p>“We will build on work already undertaken to ensure patients have direct access to MSK First Contact Practitioners (FCP).”</p>	<p>An FCP does not have to be a physiotherapist, but they must meet the requirements of this core skills framework</p> <p>The CSP have produced this guide to implementing First Contact Physiotherapy, which is equally applicable for implementing FCP with other suitably qualified professionals</p>
<p>Joint replacement surgery with no restrictions that are not clinically driven. Any restrictions on access which are not clinically driven, e.g. BMI thresholds, smoking restrictions, excessively high pain thresholds, result in delays for patients who need surgery and so conflict with the long-term plan.</p> <p>Demand for surgery should be managed through prevention and evidence-based interventions such as ESCAPE-pain.</p>	<p>“For those patients who do need an operation short waits are important.”</p>	<p>NICE pathway on Osteoarthritis</p> <p>NICE guideline on care and management of Osteoarthritis includes:</p> <p>“Base decisions on referral thresholds on discussions between patient representatives, referring clinicians and surgeons, rather than using scoring tools for prioritisation.”</p> <p>“Refer for consideration of joint surgery before there is prolonged and established functional limitation and severe pain.”</p> <p>“Patient-specific factors (including age, sex, smoking, obesity and comorbidities) should not be barriers to referral for joint surgery.”</p> <p>The NICE osteoarthritis quality standard</p>

		<p>states: “Commissioners should not restrict referral pathways on the basis of arbitrary referral thresholds, but should ensure that thresholds are agreed with patient representatives, referring clinicians and surgeons.”</p>
<p>MSK rehabilitation. Everyone should be offered appropriate community rehabilitation on leaving hospital. Failure to do this, or delays in access, results in worse outcomes, no matter how good the in-hospital care.</p>	<p>We will boost ‘out-of-hospital’ care, and finally dissolve the historic divide between primary and community health services.”</p> <p>“Extra recovery, reablement and rehabilitation support will wrap around core services to support people with the highest needs.”</p>	<p>NHS England Commissioning Guidance for Rehabilitation</p> <p>CSP Standards for Hip Fracture Rehabilitation Care</p>
<p>Community based exercise programmes e.g. ESCAPE-Pain, exercise based back pain services and community therapy services. Sufficient community services should be commissioned to meet population need without lengthy waits.</p> <p>Whilst the long-term plan references the on-line version of ESCAPE pain, the face to face programme is strongly evidence based, has a positive return on investment and, as it is delivered in a group, meets other aspects of the long-term plan such as peer support and self-management support. Everyone who would benefit should have access to the face-to-face version.</p>	<p>“Primary care networks will from 2020/21 assess their local population by risk of unwarranted health outcomes and, working with local community services, make support available to people where it is most needed.”</p> <p>“We will also expand access to support such as the online version of ESCAPE-pain (Enabling Self-management and Coping with Arthritic Pain through Exercise), a digital version of the well-established, face-to-face group programme.”</p>	<p>ESCAPE-Pain</p> <p>Moving Medicine is a web-based application to support healthcare practitioners prescribe movement for 10 conditions with support and evidence for these patient interactions.</p>

3. Prevention

The Long Term Plan sets out new commitments for action the NHS will take to improve prevention. This is very relevant to the burden of MSK disease since much of the disability caused by them could be reduced or prevented with the right interventions.

Everyone who needs it should have access, without undue waiting times, to:	Long term plan	Support and further information
<p>Strength and balance and other falls prevention services.</p>	<p>“Falls prevention schemes including exercise classes and strength and balance training can significantly reduce the likelihood of falls and are cost effective.”</p>	<p>Falls and Fracture Consensus Statement supporting commissioning for prevention</p> <p>NICE quality standard on Falls in Older People</p> <p>NICE Guidance Falls in Older People</p> <p>Falls prevention: cost-effective commissioning guidance</p>
<p>Appropriate support to ensure good nutrition and hydration to reduce risk of falls/frailty For older people, good nutrition is essential to strong, healthy bones and muscles. There should be sufficient availability of dieticians to support this.</p>	<p>“action set out in the previous chapter to redesign healthcare so that people get the right care at the right time in the optimal care setting (for example, providing better support to people living in care homes to avoid emergency hospital admissions; providing better social care and community support to slow the development of older people’s frailty” p33</p>	<p>Malnutrition Taskforce Commissioning Guidance on hydration and nutrition</p> <p>BDA Food Facts Malnutrition</p>
<p>Fracture liaison services. Fracture Liaison Services (FLS) ensure that patients are assessed after fragility fracture and offered secondary fracture prevention. By identifying and treating patients at risk of osteoporosis in a consistent, systematic way after their first fracture, it is estimated that up to 25% of hip</p>	<p>“People identified as having the greatest risks and needs will be offered targeted support.”</p>	<p>Fracture Liaison Services resources, including implementation toolkit.</p>

fractures could be prevented.		
Obesity. Interventions to manage and address obesity have an impact on MSK health. Everyone who needs it should have access to dietary and physical activity support to manage or prevent obesity.	“Obesity and poor diet are linked with type 2 diabetes, high blood pressure, high cholesterol and increased risk of respiratory, musculoskeletal and liver diseases” p36	PHE Adult Obesity guidelines PHE Childhood obesity guidelines NICE obesity prevention guidance
Public health. Public health and NHS prevention services should be integrated. Local authority public health should be a key part of the integrated care system. Primary Care Networks should ensure public health is integrated with NHS prevention.	“Action by the NHS is a complement to, but cannot be a substitute for, the important role for local government. In addition to its wider responsibilities for planning, education, housing, social care and economic development, in recent years it has also become responsible for funding and commissioning preventive health services.”	PHE Musculoskeletal Health guidance

4. Mental Health

One significant co-morbidity is musculoskeletal problems and mental health. Each condition can exacerbate the other, for example depression can make pain feel worse, and living with pain increases the risk of depression or anxiety. Psychological distress also makes self-management more of a challenge.

Everyone who needs it should have access, without undue waiting times, to:	Long term plan	Support and further information
IAPT services. All patients with a long term MSK condition should be offered access to Improving Access to Psychological Therapies (IAPT) on diagnosis.	“We will continue to expand access to IAPT services for adults and older adults with common mental health problems with a focus on those with long term conditions. IAPT services have now evolved to deliver	The Improving Access to Psychological Therapies (IAPT) Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms

	benefits to people with long term conditions, providing genuinely integrated care for people at point of delivery.”	
Integrated mental health services. People with more significant mental health problems will require more than the IAPT intervention. Rheumatology services should include/have access to mental health support as part of the service, making it easier for rheumatologists to address mental well-being.	more joined-up and coordinated in its care. Breaking down traditional barriers between care institutions, teams and funding streams so as to support the increasing number of people with long-term health conditions, rather than viewing each encounter with the health service as a single, unconnected ‘episode’ of care;	
Pain services. People with significant chronic pain should have access to integrated biopsychosocial pain services.		Core standards for pain management services in the UK Webinar: A new way of delivering MSK pain services

5. Personalisation

Universal Personalised Care: Implementing the Model, sets out more detail on how the long-term plan commitments for personalised care will be delivered. Effective implementation of this would benefit people with long term MSK conditions.

Everyone who needs it should have access to:	Universal Personalised Care: Implementing the Model	Support and further information
Social prescribing. There are many community and voluntary organisations which can provide support to people with MSK conditions. MSK patient groups are important in providing peer support. Local implementation of social prescribing should engage with these groups.	“As part of this work, through social prescribing the range of support available to people will widen, diversify and become accessible across the country. Link workers within primary care networks will work with people to develop tailored plans and connect them to local groups and support services. ...with the aim that over 900,000 people are	

	able to be referred to social prescribing schemes”	
Self- management support. Self-management is an important part of managing any long term MSK condition. The Expert Patient Programme had its origins in support for people with arthritis. Group programmes such as ESCAPE pain (see above) are also relevant to self-management. Everyone with a long-term MSK condition should have access to suitable self-management support.	“Interventions are systematically in place: health coaching, self-management education, peer support and social prescribing focussed on, though not limited to, those with low activation to build knowledge, skills and confidence, and take account of any inequalities and accessibility barriers.”	Versus Arthritis – Care Planning in Musculoskeletal Health (2014)
Personal health budgets. There are likely to be many people with long term MSK conditions who would find that a personal health budget made self-management of their condition easier.	“A person will: Be able to use the money to meet their outcomes in ways and at times that make sense to them, as agreed in their personalised care and support plan.”	Versus Arthritis - Personal Health Budgets (2012)
Shared decision making is vital in ensuring best outcomes for people with MSK conditions. NHS Rightcare has decision aids for osteoarthritis of the hip, osteoarthritis of the knee and rheumatoid arthritis. Shared decision making should be used across the pathway, not just when significant treatment is being considered.	<p>People are aware that care, treatment and support options are available, that a decision is to be made and that the decision is informed by knowledge of the pros and cons of each option and ‘what matters to me’.</p> <p>2. Clinicians are trained in shared decision-making skills, including risk communication and appropriate decision support for people at all levels of health literacy and groups who experience inequalities or exclusion.</p> <p>3. Well-designed, evidence-based decision support tools are available and</p>	<p>Rightcare decision aids https://www.england.nhs.uk/rightcare/useful-links/shared-decision-making/ Choosing Wisely recommendations which include rheumatology.</p> <p>Webinar BSR Choosing Wisely recommendations</p>

	accessible. 4. Shared decision making is built into relevant decision points in all pathways.	
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