Musculoskeletal core offer maturity matrix

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. Our Core Offer aims to help those developing local services 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. This document is designed to help assess where a local system is in terms of implementing the core offer to help identify priority areas for improvement.

The core offer covers five areas:

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

1. Underpinning framework

Effective MSK services depend on an underpinning framework of integration. Integrated Care Systems 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	0	1	2	3	4
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.		We have considered local needs in relation to our own service but there is no engagement with the question as a system.	As a system we have made some attempt to understand current prevalence of MSK conditions. MSK is mentioned in the JSNA.	As a system we have a reasonable understanding of the prevalence of different MSK conditions including chronic pain, inflammatory conditions, osteoarthritis and osteoporosis and our JSNA addresses this.	As a system we understand the current and likely future prevalence of MSK conditions including chronic pain, inflammatory conditions, osteoarthritis and osteoporosis. Our JSNA includes a specific MSK chapter.
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.		We have begun to consider workforce issues but in the main this is traditional roles and deployed in traditional structures.	We have begun to assess our current MSK workforce and consider ways to ensure we make the maximum use of the whole of that workforce.	We have mapped our MSK workforce, including the need for specialists, such as rheumatology nurses and AHPs, and identified gaps. We are thinking creatively about how to recruit to these gaps.	We are making full use of a diverse MSK workforce which includes the full range of multi-disciplinary roles. We have an understanding of future workforce needs and have plans to meet it.

Pathways. Local MSK services should be organised and commissioned in pathways, including pain medicine, orthopaedics, rheumatology and hospital/community therapy services, sport and exercise medicine, enabling patients to be rapidly directed to the appropriate point on 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. **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.		Our MSK services are fragmented but we have begun to consider how to join them up.	We have begun to implement pathways in some areas of MSK but not all areas are included.	We have some very effective MSK pathways, e.g. the National Back Pain Pathway. Not all of our MSK services are appropriately joined up and we still risk wasting resources when patients are referred inappropriately.	Every part of our MSK service is part of a widely understood pathway. The majority of patients are referred to the appropriate part of the pathway first time regardless of where they enter the system
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.		There are few prevention initiatives in the local area, mostly not commissioned by the NHS. There is little awareness of them in primary care.	We have some preventive services available e.g. Escape Pain, but we know they are insufficient to meet need or are only available in some areas. They are not well used by primary care.	We understand the role that prevention service can play in demand management and have plans for strategic investment in a range of prevention services.	We have mapped the need for a range of prevention services and are investing in these. We ensure that they are part of the MSK pathway and referral routes are well understood.

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 Spondyloarthritis, being 8.5 years. Primary Care Networks need 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.		We recognise that here is a problem with effective referrals to rheumatology services and are planning to address this. Patients often miss targets in NICE guidelines for starting evidence based treatment such as biologics.	There is a disconnect between primary care and rheumatology services. We have plans in place to ensure improvements, including primary care education.	Whilst we have good links to rheumatology services, many patients still experience delays in referrals. We are delivering primary care information and education to tackle this.	There are clear referral pathways into secondary rheumatology, early arthritis clinics ensure rapid diagnosis and primary care clinicians are skilled at recognising which patients need referral. As a result, we meet NICE guidelines for starting patients on appropriate treatment such as biologics.
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.		The extent to which work is discussed with patients is variable and infrequent.	We are supporting local clinicians, though education and information, to have conversations with patients about work and health.	Many patients will have a supportive conversation about work with at least one clinician. We are proactively supporting all clinicians to do this effectively.	Clinicians are proactive and confident in raising the impact of MSK conditions on work so that every patient of working age will have a supportive conversation about work. Fit notes are helpful to patients and employers.

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:	0	1	2	3	4
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.		We have very little FCP and no strategic commitment to expand provision.	We have some FCP services in some surgeries. We understand the contribution FCP can make to reducing primary care pressures.	We have well established FCP services which are expanding.	We have comprehensive FCP coverage so that any patient with an MSK condition can be seen by an FCP.
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.		There is insufficient supply of community rehabilitation and ineffective communication so that many people do not receive what they need.	Links between community rehabilitation and hospital are fragmented and supply is not sufficient leading to frequent lengthy delays in access.	Community rehabilitation is available but supply is not sufficient leading to some delays in access.	Everyone leaving hospital who needs community rehabilitation gets access promptly on returning home.

Joint replacement surgery should be commissioned in accordance with NICE guidance and in accordance with recognised standards of good practice. Any restrictions on access which are not clinically driven, e.g. BMI thresholds, smoking restrictions, result in delays for patients who need surgery and so conflict with the NHS long-term plan.		Any one of the following apply: - CCG policies mention opioids as being appropriate conservative treatment for osteoarthritis to avoid surgery. -CCG policies include BMI, smoking or Oxford Scores as a threshold for permitting referral for surgery. - less than 80% of patients have RTT within 18 weeks.	All of the following apply: -There is no mention of opioids as being appropriate conservative treatment for osteoarthritis. -There are no mentions of BMI, smoking or Oxford Scores used as a threshold -80% of patients or more have RTT within 18 weeks	In addition to 2 we have: -Enhanced Recovery in place -85% of patients or more have RTT within 18 weeks -Shared decision making is the norm.	In addition to 3 plus: -more than 92% of patients or more have RTT within 18 weeks
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.		There is insufficient supply of community rehabilitation and ineffective communication so that many people do not receive what they need.	Links between community rehabilitation and hospital are fragmented and supply is not sufficient leading to frequent lengthy delays in access.	Community rehabilitation is available but supply is not sufficient leading to some delays in access.	Everyone leaving hospital who needs community rehabilitation gets access promptly on returning home.

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.		There is some availability of community programmes such as ESCAPE-Pain but this is not commissioned by the CCG so that there is little join up with primary care.	We have an understanding of the local need for community-based programmes and a plan to expand access.	We are investing strategically in community-based exercise programmes which are embedded in our MSK pathways.	We have a good understanding of population need for community-based exercise programmes and commission these as part of the MSK pathway.

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:	0	1	2	3	4
Strength and balance and other falls prevention services.		We have some services to prevent falls, such as strength and balance, but these are not planned or commissioned strategically.	We have assessed the extent to which risk assessment and multifactorial interventions are available locally and begun to consider how to ensure there is sufficient to meet needs.	We have a plan in place to ensure we can meet the NICE guideline Falls in older people: assessing risk and prevention but only some aspects are currently met.	Our falls prevention services fully meet the NICE guideline Falls in older people: assessing risk and prevention

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 and other professionals to support this. Based on malnutrition pathway.		Screening and identification of malnutrition is poor, with a lack of resources to manage or help optimise nutrition intake in those at risk of malnutrition.	There is some malnutrition screening in place, but not in all areas or by all HCP. Services for the management of malnutrition exist but are not multidisciplinary.	Screening and identification is well established, with a wide range of HCPs trained. Malnutrition management and nutrition optimisation services are available but not comprehensive or always utilised, and do not always manage contributory factors.	Comprehensive screening for malnutrition is available in all areas (primary, secondary and the social care sector), with a comprehensive, multidisciplinary malnutrition management service in place which treat malnutrition and the factors contributing to it.
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. This reflects the NHS tiered weight management pathway.		There is some availability of tier two weight management services, but these may be limited to referrals to third party services with little follow up. Tier one services aimed at the public as a whole also exist but may be limited.	Tier one and two services are available more widely. Some tier three services available, but these do not reflect a fully multidisciplinary approach.	Full Weight management services are available at all tiers but are not available to all as places are limited, meaning some who would benefit from access to services are unable to do so.	We have a comprehensive tier 1-4 obesity service in place which all people with overweight or obesity can be referred as appropriate.

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 fractures could be prevented.		We recognise the benefits of an effective FLS and have begun to look at how we might implement this.	There is an FLS in one of our local trusts but it does not meet the ROS clinical standards.	We have an understanding of the local need and plans in place to ensure full coverage with quality FLS.	All relevant patients are served by an FLS which fully meets the ROS Clinical Standards.
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.		There are very few links between public health and the NHS in our area and as a result very little joint working.	We recognise the importance of the local authority in delivering prevention but joint working is sporadic.	There is some good engagement and joint work but public health is not seen as a core part of the local health system.	Public health colleagues are routinely included in ICS and PCN strategic planning.

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:	0	1	2	3	4
Pain services. People with significant chronic pain should have access to integrated biopsychosocial pain services.		There is some support for patients with chronic pain but no integrated biopsychosocial service	We have an integrated pain service, but referral routes are unclear or only available through consultants.	We have an integrated pain service, but waiting times are long or eligibility requirements high.	We have a range of integrated pain services available to everyone with significant chronic pain with short waiting times.

IAPT services. All patients with a long term MSK condition should be offered access to Improving Access to Psychological Therapies (IAPT) on diagnosis.		We have IAPT for long term conditions, but this is focused on specific conditions not including MSK so that few people with MSK conditions are referred.	People with MSK conditions can be referred to IAPT but there is no MSK specific offer.	We have an IAPT-MSK pain offer locally but it is not well engaged with other services and not routinely referred to by primary care.	We have an IAPT-MSK pain offer locally which has strong links with both community based services and support and pain services.
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.		There are referral routes for mental health support but these are not integrated with physical health. Waiting times for people with MSK conditions are long.	There are referral routes for mental health support but these are not integrated with physical health. Waiting times are not significantly longer than for other services.	There are good links between MSK services and mental health but a separate appointment in a mental health clinic is needed.	Our MSK services, such as our rheumatology clinics, have an integrated psychology element included through health psychologists or liaison psychiatry as part of the team.

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:					
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.		We have a good social prescribing service, but have not considered the needs of people with MSK conditions or chronic pain.	We have an understanding of the offers we need to meet MSK needs and have begun to scope our existing community assets.	We have a good understanding of our local community assets related to MSK services and are looking at how to commission services to fill the gaps.	Our link workers have a good understanding of what is likely to be useful to people with MSK conditions or chronic pain and we have a comprehensive range of options available to them, including peer support.
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.		GPs are expected to be able to support patients with MSK conditions with self-management. There are no services for them to refer patients to.	We have some self-management services locally but many GPs are not aware of them or how to refer.	We have some self-management services which are well used. We are looking at how to expand these to meet local need. Patients are made aware of national patient organisations and helplines relevant to their condition.	We have a range of self-management support offers including community programmes, patient led support groups and Expert Patient programme. Patients are made aware of national patient organisations and helplines relevant to their condition.

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.		There is very little take up of PHB in our area and little understanding of how this might benefit people with an MSK condition. People would have to ask for one.	People are told about PHBs but generally discouraged form taking one up.	People are offered a PHB but no support to enable them to understand whether this option is right for them and how best to manage it.	PHBs and the support needed for people to be able to make best use of them are offered to all people with MSK conditions who might be eligible.
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.		We use shared decision making as a way to discourage people from choosing services such as joint replacement.	Some clinicians involve patients in decision making but many are not familiar with key techniques and do not use shared decision making effectively.	Shared decision making is well understood and used for significant decisions, such as surgery or medication decisions, but not embedded across the pathway.	There is a good understanding of shared decision making across the MSK pathway, and patients are involved in all decisions affecting their treatment.

About ARMA

ARMA is an umbrella body representing the breadth of musculoskeletal conditions and professions.

Our vision for musculoskeletal (MSK) health:

- The MSK health of the population is promoted throughout life;
- Everyone with MSK conditions receives appropriate, high quality interventions to promote their health and well-being in a timely manner.

Our members:

Arthritis Action
Back Care
British Association of Sports Rehabilitation and Training
British Dietetic Association
British Chiropractic Association
British Orthopaedic Association
British Society of Rehabilitation Medicine
Chartered Society of Physiotherapy
College of Occupational Therapists – Specialist Section Rheumatology
Ehlers-Danlos Support UK
Faculty of Sports and Exercise Medicine
Fibromyalgia Action UK
Hypermobility Syndrome Association
The Institute of Osteopathy
Musculoskeletal Association Chartered Physiotherapists
National Ankylosing Spondylitis Society
PolyMyalgia Rheumatica and Giant Cell Arteritis (PMRGCA) UK
Podiatry Rheumatic Care Association
Primary Care Rheumatology Society
RCN - Rheumatology Forum
Rheumatology Pharmacy Network
Royal College of Chiropractors
Scleroderma & Raynaud's UK
Society of Musculoskeletal Medicine
UK Gout Society
Versus Arthritis

Dec 2019