



MSK HEALTH EQUALITIES

REPORT OF ROUNDTABLE

30 SEPTEMBER 2021

EQU
ALITI
ES

HEALTH
EQUALITIES

CONTENTS

	PAGE
About musculoskeletal conditions	3
Musculoskeletal conditions and inequalities	3
BestMSK Health Collaborative	4
Deprivation	4-5
Tackling MSK health inequalities	6-10
Case study West Yorkshire and Harrogate Health and Care Partnership	6-7
Solutions	11-13
Recommendations	14
Attendees	15
Resources	16-17

Acknowledgements

We would like to thank the following for their support of The Arthritis and Musculoskeletal Alliance (ARMA) roundtable:

Bola Owolabi, Director – Health Inequalities, NHS England and Improvement for chairing the event. Our speakers Nuzhat Ali, Public Health England; Adanna Williams, BestMSK Health Collaborative, NHS England and NHS Improvement; Liz Lingard, NHS England and NHS Improvement (North East & Yorkshire); Sarah Smith, West Yorkshire and Harrogate Health and Care Partnership. Everyone who attended the event for their input.

ARMA brings together professional and patient organisations working in MSK to influence policy and practice for better MSK health and services. Our member organisations are:

Arthritis Action	Musculoskeletal Association Chartered
Back Care	Physiotherapists National
British Association of Sport and Exercise Medicine (BASEM)	Axial Spondyloarthritis Society
British Association of Sports Rehabilitation and Training	National Rheumatoid Arthritis Society & JIA
British Chiropractic Association	Physio First
British Dietetic Association	Physiotherapy Pain Association
British Orthopaedic Association	Podiatry Rheumatic Care Association
British Society of Rehabilitation Medicine	Primary Care Rheumatology Musculoskeletal
CCAA Kids with Arthritis	Medicine Society
Chartered Society of Physiotherapy	Psoriasis Association
Cornwall Arthritis Trust	Rheumatology Pharmacists UK
Ehlers-Danlos Support UK	Royal College of Chiropractors
Faculty of Sport and Exercise Medicine	Royal College of Nursing - Rheumatology Forum
Fibromyalgia Action UK	Royal College of Podiatry
Hypermobility Syndrome Association	Royal Osteoporosis Society
The Institute of Osteopathy	Scleroderma and Raynaud's UK
McTimoney Chiropractic Association	Society of Musculoskeletal Medicine
	The Society of Sport Therapists
	UK Gout Society
	Versus Arthritis

© December 2021 Arthritis and Musculoskeletal Alliance (ARMA). While we try to make every attempt to ensure that the information in this report is correct, we do not give any express or implied warranty as to its accuracy. We do not accept liability for any error or omission. Any part of this publication may be freely reproduced for non-commercial purposes and with the appropriate acknowledgement. The contents of this document and further resources including contact details for our member organisations and further information about our work are available on the ARMA website at www.arma.uk.net.



About musculoskeletal conditions

The term musculoskeletal (MSK) conditions includes a broad range of health conditions affecting the bones, joints, muscles and spine, as well as rarer autoimmune conditions such as lupus. Common symptoms include pain, stiffness and a loss of mobility and dexterity. An estimated 18.8 million people live with a musculoskeletal condition in the UK¹. This compares to 4.7 million with diabetes, 7 million with heart disease and 1.2 million with COPD.

MSK conditions fall into three broad categories:

- Inflammatory conditions: rheumatoid arthritis, axial spondyloarthritis including ankylosing spondylitis, gout, juvenile idiopathic arthritis
- Conditions of musculoskeletal pain: osteoarthritis, back pain, fibromyalgia
- Osteoporosis and fragility fractures: e.g. fracture after fall from standing height

Musculoskeletal conditions and inequalities

There are significant inequalities in the numbers of people reporting a long term MSK condition.

- Deprivation – 19.4% of people in the most deprived decile compared with 16% in the least deprived.
- Sex – 15.7% of men and 20.6% of women.
- Ethnicity – Reports are above average in the white gypsy or Irish traveller, white British, white Irish and black Caribbean communities
- Age – MSK conditions increase with age, although 2.1% of young people aged 16 – 17 report a long term MSK condition and there are an estimated 12,000 children with Juvenile Idiopathic Arthritis, just one MSK condition experienced by children in the UK.²

MSK health impacts on other health conditions. 13.2% of the population report at least two long term conditions of which at least one is musculoskeletal. Our musculoskeletal health is what enables us to keep active, be mobile, work, study and live independently. Poor musculoskeletal health has an impact on people's ability to maintain their health and manage other health conditions. When it results in decisions to reduce or leave work and give up social activities, poor MSK can exacerbate inequalities.

¹ <https://www.versusarthritis.org/about-arthritis/data-and-statistics/state-of-musculoskeletal-health-2019/>

² <https://fingertips.phe.org.uk/profile/msk>



BestMSK Health Collaborative

Best MSK Health collaborative is an NHS England programme. The ambition is to reduce variation in access outcomes and experience for those with MSK conditions. The programme arose from 2021/22 NHSE/I operational priorities. It co-ordinates the MSK related ambitions within the NHS long term plan, aligns with Integrated Care System planning and builds upon the beneficial changes rapidly introduced in the response to the coronavirus pandemic. It puts the principles of personalised care at its heart.

There are ten workstreams:

- Orthopaedics
- Spinal
- Rheumatology
- Osteoporosis, falls and fragility fractures
- Urgent and emergency care
- Children and young people
- Diagnostics
- Primary and community care
- Supported self-management
- Data and metrics


Deprivation

We know that there is higher incidence of MSK conditions in areas of deprivation, but no difference in the incidence of interventions indicating levels of unmet need. The exact causes are not fully understood. To address these issues, we need to focus MSK improvement work in the areas of deprivation where it is most needed. It was felt that more emphasis is currently given to improvements in the less deprived areas where the work is easier.

The issues will include people on zero hours contracts who find it harder to attend appointments. The response to a DNA should not be to throw the person off the list. It is a signal that more support is required.

There is also some indication of an increase in people attending A&E as their first point of contact related to an MSK condition. This could be because they are not registered with a GP or have left symptoms so long they have become an emergency. There could be value in placing First Contact MSK Practitioners (FCPs) in A&E given the high numbers of MSK conditions presenting there.

GPs in one area of deprivation reported increasing numbers of people with degenerative MSK conditions at younger ages (in their 20s and 30s). Overwhelmingly this was felt to be driven by



obesity and other issues of deprivation. Tackling the social determinants of ill health associated with deprivation will be preventative of MSK conditions. To do this we need to shift our focus upstream into health promotion. There is a huge role for public health in MSK. Many of the solutions are outside the control of the NHS and health charities and require a co-ordinated approach including across central government, local government and private sector (e.g. employers).



Tackling MSK health inequalities

Health inequalities are not new. There have been successive reports on the issues published since the 1980s. However, there is now a focus on tackling health inequalities which we have never seen before. At the same time MSK conditions, through BestMSK Health, have a profile they never had before. This gives us a big opportunity to address these issues with a potential for success.

“We are on the precipice of doing something differently.”

The overall objective for the NHS is exceptional quality healthcare for all. The BestMSK Health programme aims to enable best lifelong MSK health within all communities. Both of these objectives require us to tackle the existing inequalities in healthcare to ensure:

- Equitable access
- Excellent experience
- Optimal outcomes.

The roundtable focused predominantly on areas of deprivation and ethnicity. However, it was recognised that all the inclusion groups are impacted and this needs to be remembered when reading this report. It was also recognised that, whilst there is a significant amount that health services can, and should, do to tackle this issue, we mustn't lose sight of wider structural inequalities (e.g. race, class, gender) and their impact.

CASE STUDY

WEST YORKSHIRE AND HARROGATE HEALTH AND CARE PARTNERSHIP

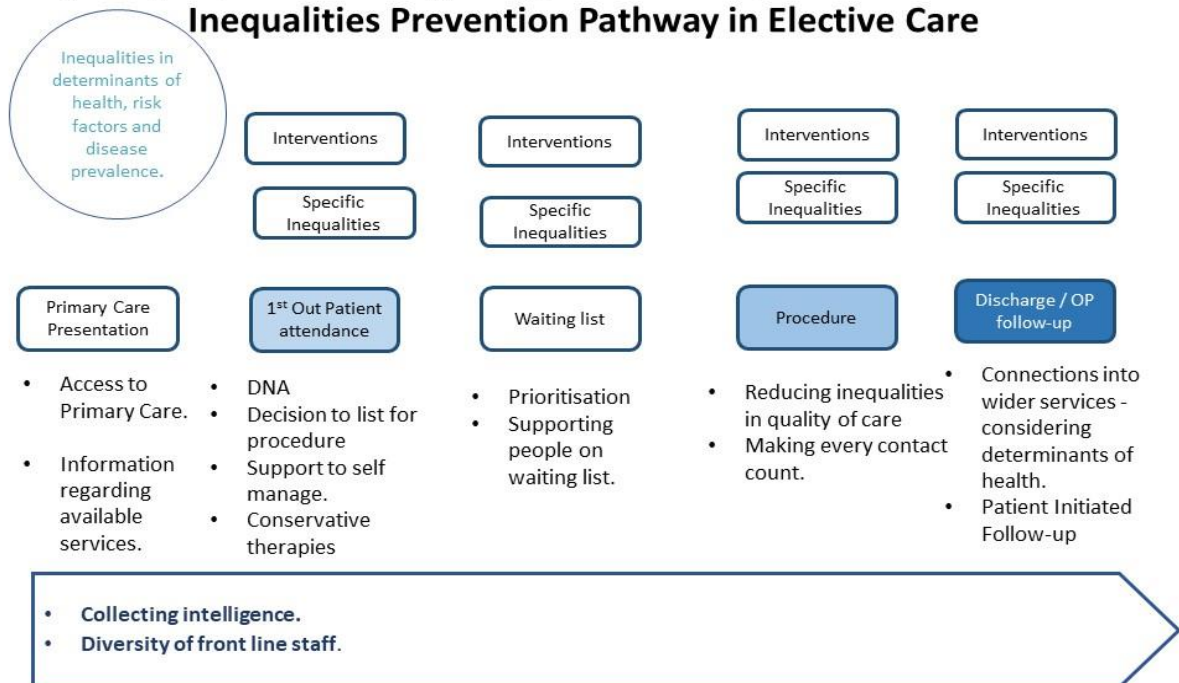
The West Yorkshire and Harrogate Health and Care Partnership (WYHHCP) has 10 big ambitions, including to increase the number of years that people live in good health and reduce the gap in life expectancy by 5% in our most deprived communities.

Analysis of the data showed that after adjusting for the age demographics of the population, there is a difference in the rate of hip replacement between a CCG's most and least deprived population with significantly lower rate of hip replacements in the less deprived areas. The factors related to the causes of these inequalities are likely to be complex, and require further consideration, as does the impact on reducing these inequalities on the health and care system as a whole.

WYHHCP recognise that inequitable access to services that are timely, appropriate, sensitive and easy to use can result in particular groups receiving less care relative to their needs, or more inappropriate or sub-optimal care, than others. This often leads to poorer experiences, outcomes and health status. Access to the full range of services that can have an impact on health includes access to preventive interventions and social services, as well as primary and secondary health care.


The partnership is now taking a quality improvement approach to developing a health inequalities prevention pathway in elective care

Quality Improvement Type Approaches: Application of the Health Inequalities Prevention Pathway in Elective Care



Digital access and health literacy

Increasing use of digital in health services can bring significant benefits. However, some groups are excluded from this due to digital poverty, poor digital literacy or both. We need to ensure that no one is left behind. This can be achieved through tackling the barriers to digital access and/or by providing alternatives. A digital first approach will exclude people and should be avoided. However, simply providing alternatives for those who find digital difficult to access risks excluding people from the benefits digital can bring.



Health literacy is also a significant issue. The proportion of people who have difficulty understanding written information is more than double in the 20% most deprived areas compared to the least deprived 20%. Health literacy also relates to the way information is written. Nationally 61% of adults find health information too difficult to understand. People producing health information need to ensure that it can be easily understood by the intended audience.³

Communities

If professionals continue to make their services available as they have in the past then the same people will make use of those services. Changing this requires rethinking how and where services are provided.

The biggest opportunities for reducing health inequalities are at the margins of populations, those people who are seldom heard. Current delivery models are not reaching these people, so they need to be adjusted to enable us to reach them. Whether we are tackling digital exclusion, health literacy, or deprivation we need to refocus on those who currently have the least access.


This has to be driven by listening to those communities. This is what drove up COVID-19 vaccination uptake, for instance, in black African communities in London. We can learn from this experience and apply to other health issues, including MSK. Coproduction is the only way to ensure services meet the needs of communities. NHS leadership needs to work with communities and local leaders who best understand local cultures and resources to lead and formulate a strategy. We need the NHS to catalyse and support community champions to communicate in ways which are appropriate. There is limited capacity in the NHS, especially in primary care. We therefore need to work with all the resources we have available in local communities.

It was noted that there are people who don't feel part of a community and COVID has exacerbated this. There are now many people who don't go out and interact, especially in big cities. We need to consider how we engage these people as well.

Prevention

Much of the burden of MSK conditions is preventable. However, it can be very difficult to get investment in prevention. There are areas where healthy life expectancy is several years before retirement age and MSK will be a significant component of this. There are costs associated with the

³ Simpson, R.M. orcid.org/0000-0003-1677-5938, Knowles, E. and O'Cathain, A. (2020) Health literacy levels of British adults: a cross-sectional survey using two domains of the Health Literacy Questionnaire (HLQ). *BMC Public Health*, 20 (1). 1819. ISSN 1471-2458 <https://eprints.whiterose.ac.uk/168783/1/s12889-020-09727-w.pdf>



fact that people are not contributing to the economy during this time, as well as making use of NHS services. We need to make a business case that treating someone early saves money.

Children and young people

Children are important for two reasons:

Prevention – Bone health is established in teenage years and early 20s. MSK health needs to be promoted across the whole life course.

Children and young people with MSK conditions - A lot of the commonly used data on incidence of MSK conditions includes only adults. Conditions such as Juvenile Idiopathic Arthritis have a significant lifelong impact and put children at a disadvantaged compared to their peers. Delays in diagnosis and appropriate treatment can lead to long term damage to joints. Children's voices are not well heard and they are very dependent on their parents to advocate for them. Those whose parents will find this advocacy role difficult are likely to face poorer health outcomes in the long term.


Data

Data needs to be used to drive insight and change. If we can disaggregate data, we can see where the issues are. Which groups are getting less access to primary care or to treatments? Who is starting to use opioids but not accessing any other support? Does the level of access correlate with areas or groups where we know there is a high level of need? Which groups are waiting the longest?

The discussion identified a range of problems with use of data. Data is absent, for instance ethnicity coding in the NHS is poor, as is MSK data in primary and community services. There is little or no join up between primary, secondary and social care data. Qualitative data is also important, information about what is important to patients, details of their lives.

Waiting lists

There are inequalities in the currently lengthy waits for orthopaedic surgery. We know that length of the wait matters. Longer waits lead to poorer outcomes. In the least deprived areas 4% wait more than a year. That figure is almost double in the most deprived. A range of factors impact this. Health services in these areas were hit hardest with covid so impact will last longer. Health literacy also affects whether you get to secondary care and the length of your wait. To address this we need to



break down data on waiting times by deprivation, ethnicity, disability, etc to enable us to address this.

The same is true in recovery of MSK services. In the most deprived areas access is still significantly impaired. If we are to tackle MSK health inequalities, restoring NHS services inclusively needs to be a top priority.

Care gap

There is a lot of focus on elective surgery such as hip and knee replacement. However, a tiny fraction of people with MSK conditions will require this type of treatment. The majority of MSK conditions are long term conditions which require ongoing management. This requires good community MSK services and a preventative population approach embedded in the principles of a biopsychosocial approach. This is particularly true in pain management where there is little to support primary care in providing alternatives to opioid prescription.

The transition between diagnosis of a long term MSK condition and that condition becoming disabling depends on the effectiveness of this ongoing management. One contribution to inequalities is what was termed the “care gap”, where a condition is considered not bad enough for secondary care, but where effective management needs more specialist support than can be delivered in primary care. Access to services which support self-management is more difficult in deprived areas, where we know the prevalence of such conditions is highest. Reducing inequalities in healthy life expectancy will require reducing inequalities in how well conditions are managed.

Status of MSK

Historically the status of MSK conditions has not reflected the impact on society and the burden of disease it brings. It doesn't reflect the importance of good MSK health to people being able to grow, live and age well. The focus of restoration, reductions in waiting times and the BestMSK Health programme in NHSE is starting to change this. Given the impact of MSK conditions on our ability to manage other health conditions, tackling inequalities in health cannot be achieved without giving a high priority to MSK.



Solutions

Inequalities in MSK are complex so solutions need to address complexity and tackle a variety of issues. Solutions need to focus where it is difficult as this is where the greatest gains can be made. We can learn from other disease groups and from experiences related to covid and long covid and translate their ideas to MSK.

As the largest cause of years lived with disability, MSK health has a value to healthcare system, the welfare state, a social value, and an economic value. This value is beginning to be recognised particularly in the current context around elective care waiting times. However, it needs to be recognised across MSK.

Tackling complexity

Quality improvement gives a methodology to address complexity:


- 1) Data for improvement – virtuous circles of data to give actionable insights, drive interventions and get a sense of what works.
- 2) Strengths based approach. The problem is not with the communities who face inequalities but with our inability to provide access. We need to build on the assets in those communities.
- 3) Coproduction. The communities who face these inequalities often have the most creative, cost effective and sustainable solutions.

Data

Using data to identify where the biggest challenges and the greatest opportunities are should be a starting point for work to improve MSK health and equalities. Work on improving data, including the data workstream of BestMSK health, should address the need for data to support work on health inequalities, especially in primary and community services.

Working with communities

The biggest difference will be made by tackling the most excluded groups. Working with champions in the community is essential. This will help reduce barriers and build trust. A community asset-based approach is essential, which requires a mindset change within the NHS.

- 
- Co-production - hearing the patient and public voice.
 - Community based MSK champions.
 - Using spaces that are non-traditional where people can access health and care. MSK is ideally suited to this and already does so in some areas e.g. delivering ESCAPE-pain in gyms and community centres.
 - Engage local authority, leisure and parks, public health directors and voluntary sector.

Services

We need to consider how to design services which make it easy for people to access.

- Flexibility – we need a flexible offer for access especially into primary care. For some digital can offer improved access, e.g. remote appointments without needing to take time off work. We need to ensure access for those for whom digital doesn't work.
- Case finding – People who don't get into services in the first place. This unmet and unrecognised need drives inequalities. The current waiting lists don't reflect the level of need.
- Waiting list prioritisation – should be objective and based on clinical need
- Social prescribing - could play a big role in supporting people with MSK conditions to manage their conditions. Social prescribing can also offer support with employment issues and benefits, for instance, which can create challenges for people in managing their health.


Children and Young People

Work on inequalities and MSK needs to include children and young people with MSK conditions. Good recognition of conditions such as JIA in primary care and NICE pathways which work well are required. Long term prevention measures to promote bone health, such as getting children more active, also need to focus on the most excluded children.

Professionals' responsibility

We need a workforce, with the skills needed to address these issues, and an understanding of their role and responsibility. The behaviour of professionals has a big influence on people's experience and therefore on their future interactions with services. Education and training to skill the workforce in discrimination, unconscious bias is required.

There are also issues of the representativeness of the workforce of the populations they serve. For instance, physiotherapy is predominantly white and middle class and therefore not representative of those in most need. This is something that will take time to change.



There is a need to be clear where responsibility and accountability sits. Action is needed at every level - national, ICS, PCN, the professions, commissioners and individual professionals all have a role to play.

Recommendations

There is now a collective will to address these issues. Never before has there been this level of focus and consensus on inequalities, nor this level of profile for MSK. This should generate optimism that we can make a difference.

1. DATA

- All work on improving MSK data should include consideration of health inequalities
- Data should be used to drive insight and interventions

2. STATUS OF MSK

- All health care professionals and managers at every level should recognise the value of MSK health and give it a priority commensurate with this value.
- There are many resources to support MSK improvement which need to be made readily available and used in local improvement work
- MSK professionals should join the BestMSK Health community of practice to access resources

3. COMMUNITIES

- Focus on the most marginalised communities, those where the activity and engagement with services is lower than would be expected given the expected incidence of MSK conditions
- Work with communities through coproduction, community leaders and develop MSK champions
- Use a strengths based approach
- Engage all stakeholders including local authority, parks, leisure, etc.
- Active case finding in areas with lower than expected identification of MSK conditions
- Develop flexible services in non-traditional spaces

4. ADDRESS THE CARE GAP

- Focus on self-management support, where the most benefit can be delivered for the most people
- Coproduce these services, focusing on areas of low take up
- Ensure social prescribing services are equipped to support people with MSK conditions

5. CHILDREN AND YOUNG PEOPLE

- Ensure a similar focus on equality in MSK services for children and young people, coproducing with young people and parents

6. ACCESS TO DIGITAL AND INFORMATION

- Identify causes of digital exclusion and coproduce solutions
- Ensure health information is accessible to the intended audience (plain English, community languages, accessible information standard)

7. WORKFORCE

- Ensure the workforce is trained and supported to work on this agenda



Attendees

Adanna Williams, Deputy Director - BestMSK Health Collaborative, NHS England and NHS Improvement

Aleyah Babb-Benjamin, Outreach and Insight Manager, National Voices

Alison Giles, Associate Director (Healthy Ageing), Centre for Ageing Better

Andrew Bennett, National Clinical Director MSK, NHS England and Improvement

Asim Suleiman, GPwER Pain Management

Bola Owolabi, Director – Health Inequalities, NHS England and Improvement

Charlotte Paddison, Deputy Director of Policy, Nuffield Trust

Craig Nikolic, Chief Operating Officer, Together First CIC, Barking & Dagenham's GP Federation

Dale Webb, Chief Executive, National Axial Spondyloarthritis Society

Ginder Narle, MSK Policy Implementation Manager, Public Health England/Versus Arthritis

Helena Marzo-Ortega, Rheumatologist

Imelda Redmond, National Director, Healthwatch England

Jane Taylor, ARMA trustee

John Skinner, President, British Orthopaedic Association

Jonathan Pearson-Stuttard, Chair of Health Inequalities Programme Board, Northumbria Healthcare NHS Foundation Trust

Liz Lingard, Delivery Partner, System Improvement, NHS England and NHS Improvement (North East & Yorkshire)

Mini Mangat, Head of Patient Engagement, Connect Health

Natalie Beswetherick, Director of Practice & Development, Chartered Society of Physiotherapy

Nita Parmar, Public Affairs and Communications Lead, Arthritis and Musculoskeletal Alliance

Nuzhat Ali, National Lead Musculoskeletal Health and Wellbeing, Public Health England

Sarah Smith, Programme Director, Improving Population Health, West Yorkshire and Harrogate Health and Care Partnership

Sue Brown, Chief Executive, Arthritis and Musculoskeletal Alliance

Tracey Bignall, Senior Policy and Practice Officer, Race Equality Foundation



Resources

The following resources were referred to during the discussion or may provide helpful background to the issues.

BestMSK Health Programme

For those wanting to know more about Best MSK Health programme there is a growing community of practice and a home for the key documents and where you can get a closer look at the activities in our programme. You have to register to request access currently.

<https://future.nhs.uk/NationalMSKHealth/grouphome>

All of the NE Yorkshire Health Inequalities information is available via C-Works. If you are not already a member of C-Works, please email LKISNorthEastandYorkshire@phe.gov.uk to join.

MSK conditions

Why are musculoskeletal conditions the biggest contributor to morbidity? (March 2019)

Public Health England and Versus Arthritis

<https://ukhsa.blog.gov.uk/2019/03/11/why-are-musculoskeletal-conditions-the-biggest-contributor-to-morbidity/>

Muscle and bone strengthening activities for children and young people 5 to 18 years (January 2021)
PHE and Royal Osteoporosis Society

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/949958/CYP_MSBS_Review_1_.pdf

Wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults (August 2021)

Public Health England

<https://www.gov.uk/government/publications/covid-19-wider-impacts-on-people-aged-65-and-over>

The State of Musculoskeletal Health 2021

Versus Arthritis

<https://www.versusarthritis.org/about-arthritis/data-and-statistics/the-state-of-musculoskeletal-health/>

Musculoskeletal Conditions Profile (November 2021)

Public Health England

<https://fingertips.phe.org.uk/profile/msk>

Health inequalities


Building back inclusively: Radical approaches to tackling the elective backlog (September 2021)

NHS Confederation

<https://www.nhsconfed.org/sites/default/files/2021-09/Building-back-inclusively.pdf>

Musculoskeletal conditions and Black, Asian and minority ethnic people: addressing health inequalities. (May 2020)

Race Equality Foundation



<https://raceequalityfoundation.org.uk/health-care/musculoskeletal-conditions-and-bame-people-addressing-health-inequalities/>

People living in the poorest areas waiting longer for hospital treatment (September 2021)

Healthwatch in partnership with the Kings Fund

<https://www.healthwatch.co.uk/news/2021-09-27/people-living-poorest-areas-waiting-longer-hospital-treatment>

My role in tackling health inequalities: a framework for allied health professionals (June 2021)

Kings Fund

<https://www.kingsfund.org.uk/publications/tackling-health-inequalities-framework-allied-health-professionals>

Core20PLUS5 – An approach to reducing health inequalities (November 2021)

NHS England and NHS Improvement

<https://www.england.nhs.uk/publication/core20plus5-an-approach-to-reducing-health-inequalities-supporting-information/>

Health Literacy: What's it got to do with me? (2020)

University of Bolton

<https://www.bolton.ac.uk/leaponline/Documents/LEAP-Printables/Health-Literacy.pdf>

You only had to ask: What people with multiple conditions say about health equity (July 2021)

The Richmond Group of Charities and Impact on Urban Health

<https://richmondgroupofcharities.org.uk/taskforce-multiple-conditions>

Arthritis and Musculoskeletal Alliance

Tel: +44 (0) 203 856 1978

projects@arma.uk.net

www.arma.uk.net

@WeAreArma

Registered Charity No: 1108851

Registered Company No: 5380237