

## Musculoskeletal Service Improvement

### Key messages



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## Key ARMA messages

ARMA believes that a number of things are required if people with musculoskeletal (MSK) conditions are to receive the support they need. The key messages below are designed for anyone involved in, or being consulted about, MSK service improvement, redesign or transformation. They aim to help identify some of the questions you may wish to ask or points you may wish to make. Not every point will be relevant in every discussion. Use the ones that are most useful for the meeting or consultation you are in. You may need to adapt the language and context depending on your role, but the principles are the same whether you are a professional, voluntary sector representative or person with lived experience.

If you are someone with lived experience, you might find [this resource](#) useful in understanding how to make co-production more effective.

### Key questions to ask

These are some overarching questions that ARMA believes everyone who is involved in service improvement, redesign or transformation should be asking. We believe these questions can make the work more effective in the long term.

- Are all the relevant stakeholders, including people who use our services, included in this work?
- Are we considering the knock on impact of these proposals on other parts of the system? (e.g. If we increase the rate of joint replacements, do we have enough community rehabilitation in place?)
- Are we thinking about patients or just focussing on the needs of the system and clinicians?
- Are we considering the role of social prescribing, health coaching, peer support, mental health support in what we offer?
- Are we thinking widely enough about the workforce who could deliver?
- What are we doing to reduce inequalities and avoid inadvertently increasing inequalities?
- Is this ICS focusing across the breadth of MSK as a system, including orthopaedics, rheumatology, primary, community and pain services?

### 1. Co-production

#### Involvement of both patients and patient member organisations in service design

It is essential to involve people with lived experience of MSK conditions in any service redesign, improvement or transformation. Of course, we need to address problems for the system and make changes as easy as possible for clinicians. But if changes make things harder for patients they will be ineffective. Patients often have creative ideas about how to improve services and professionals second guessing what patients will want can lead to wrong decisions. For instance, many professionals wrongly believe that patients will be resistant to groups consultations when in fact many actively prefer this for the management of a long term condition.

- How are we engaging people who use our services in this process?

- Does this give us a broad range of views?
- Are we listening to and acting on what they say?

## 2. MSK services

### **Effective MSK pathways in place – including integration with other services such as mental health, social prescribing, etc.**

MSK pathways should set out what is available for people with MSK conditions. They are usually for specific conditions. Although they are called pathways, they should not be linear, with everyone starting at the same point and moving through the pathway step by step. People should access what they need at the right time, not have access denied because hoops have to be jumped through to reach a particular “stage” of the pathway. Some people will need several things at once.

Pathways are often shown as flow diagrams, which can imply that they are linear. If you are commenting on a pathway, look out for:

- Does the pathway have links to all the services people might need – e.g. IAPT/NHS Talking Therapies, social prescribing, signposting to relevant patient organisations?
- Does the pathway cover the whole patient journey including primary care, community services and secondary care?
- Does the pathway refer to shared decision making and personalised care based on what matters to people?
- Where appropriate, does the pathway include preventative services, e.g. ESCAPE pain for joint pain, fracture liaison services?

### **Availability of sufficient community MSK services, rehabilitation services and community pain services.**

The majority of people with an MSK condition do not need treatment in secondary care. Most of those who do need secondary care also need community services, e.g. post-operative rehabilitation. Community services and self management support are vital. Discussion of MSK secondary care can sometimes be siloed, considering only the secondary care part of the pathway. It is vital to consider the impact across the pathway. For instance, increasing the rate of surgery to catch up backlogs will create problems if sufficient community rehabilitation is not available.

It is important to make sure enough funding and focus is put on things like:

- Physical therapy (which can include a range of physical MSK therapists e.g. physiotherapists, osteopaths, chiropractors).
- Rehabilitation (which can include graduate sport therapists, podiatrists).
- Support to self-manage, which can include peer support, support from patient organisations, specific self-management services

Not all community services need to be based in health services. Some of the best are in community locations such as leisure centres, parks and swimming pools.

- Have we considered the impact of this discussion on community services?
- Do we have sufficient community capacity to relieve pressure on primary and secondary care?

- Are we making the best use of community workforce and resources, including outside the NHS?

### **Availability of fracture liaison services.**

People with osteoporosis are at high risk of a “fragility fracture” as their bones are not as strong as they should be. Fracture liaison services (FLS) are designed to identify people who have had a fragility fracture as we know they are at much higher risk of having another. Hip fractures in particular are very expensive for the NHS to treat and very damaging to the person. FLS have been shown to prevent fractures and to save money, but they are not provided everywhere and not all FLS meet the required standards.

- Ask if there is a FLS in place and if so, how well is the service performing and what population does it serve?
- If there is no FLS provision in place, ask what secondary fracture prevention provision is in place to identify fragility fractures and prevent secondary fractures.

Anyone working on fracture liaison services should contact the Royal Osteoporosis Society who can provide FLS benefits calculation for ICBs, NHS Trusts and Health Boards. [FLS@theros.org.uk](mailto:FLS@theros.org.uk)

### **Measures to promote early diagnosis and rapid access to appropriate treatment.**

Care needs to begin where people first present to health services, which is normally primary care. There are some conditions, such as Axial Spondyloarthritis, fibromyalgia, rheumatoid arthritis, osteoporosis, etc. where people often face long delays in getting the correct diagnosis and access to the correct treatments and support. If you are working on services where there is a risk of delays in diagnosis, ask:

- What is being done to reduce delays in diagnosis?
- Are people aware of, and using, the [guidance on urgent and emergency referrals](#), for instance.

### **Appropriate use of technology**

Technology and digital solutions can make a big difference for people accessing MSK services. They can provide easier to use, efficient options and can benefit many people who find them an easy alternative to going to a physical building with all the associated travel, time off work, etc. See the MSK digital playbook for information about some of the options.

However, they need to be used with care if some people are not to be excluded. People may not be able to use digital options for a variety of reasons. About 9 million people in the UK cannot use the internet without help. Access requires Wi-Fi or phone data which some people cannot afford. Some people live in houses with no phone signal, so cannot access things like texts while at home. These issues affect people of all ages. Many older people are quite proficient at use of digital technology. Many younger people cannot afford data. Where a digital solution is aimed at making things easier for clinicians it is important to make sure that this doesn't inadvertently make things harder for patients.

Things to consider when implementing digital solutions:

- Who might not benefit from this? What alternatives will we offer for those who don't benefit?
- Who will benefit most and how do we make sure they are offered it?
- Are we making this change to benefit people with MSK conditions, professionals or the system?

### **3. Wider access to services**

#### **Focus on prevention.**

Not all MSK conditions can be prevented, but some can and many of the negative impacts can be significantly reduced. ESCAPE pain has been shown to reduce the number of people who want a joint replacement because they are more able to manage. Not all prevention takes a long time to have an impact. Getting people in pain more active is a quick way to make a positive impact, unlike some other prevention programmes which can take years to make a significant difference.

Prevention can be through social prescribing, health coaching, peer support, specific programmes such as ESCAPE Pain, self-management support, Fracture Liaison Services. National patient organisations offer some of this online as well as through local groups.

Public health and local communities are also important in measures to encourage people to be more active, stop smoking, access healthy food, etc. Welcoming gyms and leisure centres, green spaces, active transport plans, community groups can all play a part.

- Ask what is being done to prevent or reduce the impact of MSK conditions.
- Are the right services and support available locally and are people referred?
- How can we engage with wider partners to promote better MSK health in the local population?

#### **Ensuring rapid access to mental health support integration between MSK and mental health services.**

People with MSK conditions have higher levels of anxiety and depression. This can make their condition worse and self management harder. Everyone with an MSK condition should be asked about their mental well being and signposted to appropriate support services. This can be social prescribing or a local support group. For others a mental health service will be required. NHS Talking Therapies (IAPT) services provide support with depression and anxiety for those with long term conditions and many NHS Talking Therapies services have a pain pathway. Others will require more intensive psychological support.

- Does the local NHS Talking Therapies (IAPT) service have a pain pathway? If not, what can be done to develop one?
- How easy is it to refer people to mental health support? For instance, can a rheumatologist make a referral or does the person have to go back to their GP for that?
- Does our MSK service engage with local mental health and wellbeing services to ensure good integration?

**MSK services should link with social prescribing and health coaching services to ensure people with MSK conditions receive appropriate support.**

Make sure that the benefits of social prescribing and health coaching are included in documents and plans wherever appropriate. The impact of MSK conditions will be made worse by issues such as loneliness, stress, debt, lack of activity. Social prescribing is ideally placed to support with these issues. Some areas are developing specific social prescribing for chronic pain or common MSK conditions. Many people with MSK conditions don't need a specific service provided staff have some basic understanding of what can help. ARMA has produced a [resource guide](#) for social prescribing services about how to support MSK conditions.

- Does everyone who would benefit get a referral to social prescribing?
- Does our local service have the ARMA resource?
- Is there a need for a more specific social prescribing offer for people with MSK conditions?

**A key role for patient organisations in supporting people with MSK conditions.**

Patient organisations can support people by providing information, self management support, advice, peer support, meeting others with the same condition. Yet too often people are unaware of the organisations which could support them.

- Is signposting to patient organisations, locally and nationally, mentioned in our documents and plans?
- What else can we do to ensure that people are made aware of the various patient organisations that might support them?
- What local patient organisations exist and how can we support them?

#### **4. Workforce and funding**

**Availability of an appropriately broad, skilled MSK workforce to enable effective MDT working.**

Workforce is one of the biggest barriers to improving services in the NHS. There are a huge range of MSK professionals who can contribute to services. Using the full range of appropriate professionals can help ensure there is sufficient local workforce and ensure a wide range of skills are available. It is essential to consider this across primary, community and secondary care, not each individually.

Community MSK services have traditionally focused on physiotherapy. Other Allied Health Professionals including osteopaths, occupational therapists, podiatrists, dieticians, should be involved. With appropriate clinical governance, the addition of other professionals (e.g. graduate sport therapists, sport rehabilitators, chiropractors) can add to the effectiveness of a team. Done well, expanding the professional mix of a team will help ensure patients see someone with the right skills for their needs.

Primary care should have sufficient MSK specialists such as GPs with a special interest in MSK and First Contact MSK Practitioners. In secondary care there will be a need for sufficient consultants, specialist nurses and physiotherapists, etc.

- What level of staffing do we need to meet the MSK needs of our population across primary, community and secondary care?
- Where are the gaps and how will we fill them?
- Could we improve our services by looking at a wider range of professionals to deliver them?

### **Commissioning and funding considered across the pathway**

Funding should be allocated to meet needs. Where the services, particularly community services, are not available, they need to be commissioned. When funding is limited it is important to ensure it is spent where it will make the most difference. The starting point for this must be understanding the needs of the population.

- What do we know about the incidence and prevalence of MSK conditions in our local population?
- How much do we currently spend on MSK services? Could we make better use of this funding, e.g. by shifting to prevention, community services or investing in different service models?
- Does MSK get a high enough priority in spending to reflect the fact that it is the largest cause of years lived with disability?

## **5. Health equalities**

### **Focus on reducing inequalities of access, outcomes and experience.**

There are big inequalities in MSK health. People in deprived areas have higher rates of MSK conditions but wait longer for treatment. Men and women, different ages and ethnicities have different rates of MSK conditions and face different barriers to accessing treatment. Unless this is specifically addressed, these inequalities will persist and potentially get worse. A focus solely on reducing waiting lists, for instance, could lead to priority being given to the easiest and fastest cases to treat, unless this is taken into account.

Reference to addressing inequalities should appear in all plans, documents and pathways. Explicit work will be needed to identify local inequalities and what can be done about them.

- How will this piece of work impact on health inequalities? What can we do to improve this?
- What do we know about inequalities in access, outcomes and experience of MSK health locally?
- How are we measuring success for this change? Will that have unintended consequences for health equalities?

## **6. Barriers to access**

### **No non clinical restrictions on access to treatment**

Access to the right treatment should be based purely on clinical evidence of effectiveness and a shared decision between patient and clinician(s). Non clinical restrictions, such as BMI thresholds for access to surgery, are against NICE guidance, and increase inequalities. If a patient has a

characteristic that makes their surgery higher risk than only a shared decision between them and the clinician can establish if it is an acceptable risk given the potential benefits.

No one who needs treatment should be removed from waiting lists for failure to attend an appointment. This has a very negative impact on health inequalities. People who do not attend appointments should be contacted to find out what the problem is and how the service can address this. Reasons could include inability to read the small print on the letter inviting for appointment, inability to get to appointments, etc.

Where such measures are used to keep waiting times down this is counterproductive. The people denied access to appropriate treatment in this way are still in need and will continue to seek help using valuable NHS resources.

- Do we currently have any non-clinical restrictions on access to treatment in our pathways and what steps are we taking to remove them?
- What policies and practices are in place to minimise the impact of patient appointment non-attendance on health inequalities, and on health outcomes for the local population?

### Acronyms in this document

|                              |  |
|------------------------------|--|
| BMI                          | Body Mass Index (BMI) is one method for determining if a person is over or under weight.   |
| IAPT (NHS Talking Therapies) | Improving Access to Psychological Therapies (IAPT) services is the old name for NHS Talking Therapies. They can help with common mental health problems like stress, anxiety and depression. Services are available for people with long term conditions and some NHS Talking Therapies have a pain pathway. The name change only occurred in December 2022 so you may hear both terms used.   |
| ICS/ICB                      | Integrated care systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services. There are 42 ICS areas covering the whole of England. Each has an integrated care board (ICB), an NHS body responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area. |
| MSK                          | Musculoskeletal. MSK conditions include all conditions related to bones, joints, muscles and connective tissue.  |
| NICE                         | The National Institute for Health and Care Excellence (NICE) produces evidence-based recommendations on best practice, what is effective and what is cost effective.   |



## MSK health services

Under-provision of the items on this page will increase pressure on page 2 and primary care. Most people with a long term MSK condition will use only services on this page.

**Outside the scope of ICS:** Wider Government policies impact on MSK health.

### MSK health promotion

– activity levels, obesity, smoking, healthy diet

- Schools
- Leisure services (local government and private)
- Parks
- Employers
- Education (lifelong MSK health)
- Voluntary sector activities (e.g. parkrun, Good Gym)
- Older people's services
- Public health programmes e.g. smoking cessation

### Private practitioners

- Physiotherapy, chiropractor, podiatry, osteopathy, graduate sport therapists often (and increasingly) first port of call.
- Understanding modern approaches to MSK
- Recognising red flags

### Community services and Long term condition management

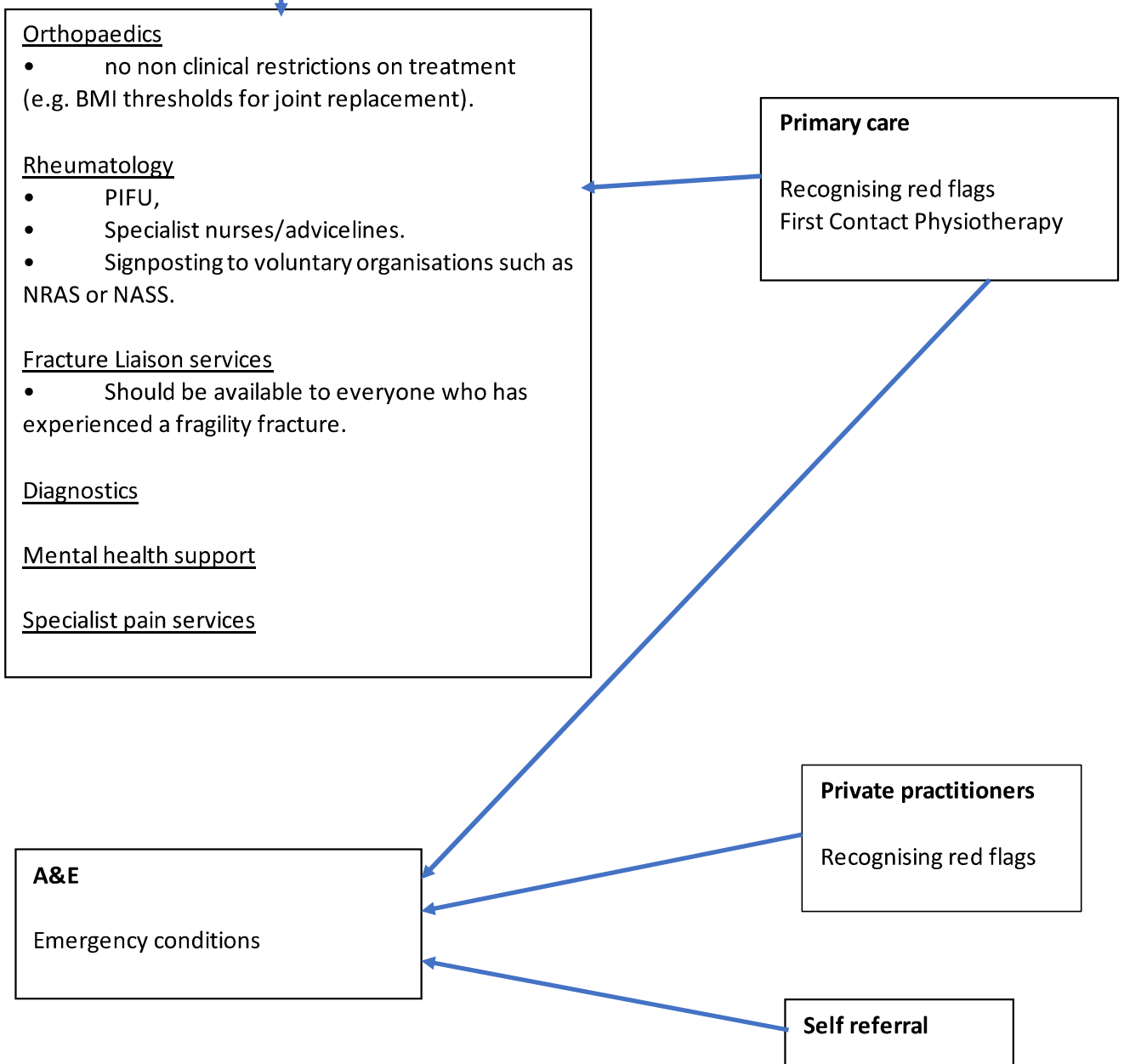
- Physical therapy
- Personalised care principles
- Shared decision making
- Health coaching
- Strength, balance, falls prevention
- Mental health support – including IAPT pain pathway
- Community pain services
- Support for non inflammatory conditions such as fibromyalgia
- Post hospital rehabilitation
- Schools and employers supporting those with long term conditions
- Peer support – voluntary sector, group consultations, group self management programmes (e.g. ESCAPE Pain)
- Self management education

### Primary care

- Social prescribing
- Health coaching
- First Contact MSK Practitioners
- Pharmacy (esp pain management)


### Self referral


## Secondary care



Referral optimisation to secondary care is possible only if items on the previous page are available and sufficient to meet population need.

## Useful documents and resources

Some of the documents listed below (marked ) are listed on the [NHS Futures site](#). To access these you will need to register for access to the site and then request access to the Best MSK Health workspace. Anyone can register.

 Best MSK Health [High Impact Strategy](#) contains 11 recommendations which cross the whole MSK pathway and specialty specific recommendations, primary and community recommendations and diagnostic recommendations.

### Delays in diagnosis

Urgent and Emergency Musculoskeletal Conditions Requiring Onward Referral

[This guidance](#) supports primary and community care practitioners in recognising serious pathology which requires emergency or urgent referral to secondary care in a patient who present with new or worsening musculoskeletal (MSK) symptoms.

Act on Axial SpA

[Resources](#) to reduce delays in diagnosis

### Digital

MSK Digital Playbook

[A resource](#) providing support to clinical teams and organisations that are looking for digital tools that support the delivery of patient pathways.

### Understanding local need

Musculoskeletal conditions profile

[A tool](#) to provide meaningful data, on a single platform, to enable the commissioning of high value musculoskeletal services. Data by local authority area.

The State of Musculoskeletal Health

Versus Arthritis produces a [range of information](#) about MSK data, including an annual report on the state of MSK health.

### Social Prescribing and self management support

Social prescribing and musculoskeletal health

[A guide](#) for link workers and social prescribing services

Patient organisations

Many patient organisations provide peer support and other self management support for people with MSK conditions. See the list in the social prescribing resource above.

### Health Inequalities

MSK Health inequalities resource page

This [resource page](#) is designed to signpost to the most relevant and useful resources and information specifically about MSK health inequalities.

### Primary and community MSK services

An improvement framework to reduce community musculoskeletal waits while delivering best outcomes and experience

[A framework](#) to support integrated care systems (ICSs) to reduce commissioned community MSK waiting times.

🔗 Primary and community care musculoskeletal (MSK) recovery and transformation guidance toolkit  
[The toolkit](#) provides best practice clinical guidance and evidenced based resources which support musculoskeletal (MSK) recovery and transformation opportunities across the MSK pathway for patients with hip and knee osteoarthritis, spinal pain and sciatica and shoulder pain in primary and community care.

Add supported self management toolkit once it is out (and the pain one if it comes out in time).

### Relevant NICE guidance

The main guidelines for MSK are:

[Chronic pain \(primary and secondary\) in over 16s](#): assessment of all chronic pain and management of chronic primary pain

[Low back pain and sciatica in over 16s](#)

[Osteoporosis: assessing the risk of fragility fracture](#)

[Rheumatoid arthritis in adults: management](#)

[Nice Quality Standard Rheumatoid arthritis in over 16s](#)

[Spondyloarthritis in over 16s](#)

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