ICB APPROACH TO MUSCULOSKELETAL SERVICES WITHIN THEIR AREA

ARMA FREEDOM OF INFORMATION RESPONSE AND REGIONAL MEETINGS ANALYSIS

August 2024

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Introduction

In March 2024 ARMA sent Freedom of Information (FOI) requests to every Integrated Care Board (ICB) asking about their leadership and priorities for MSK. This report summarises the responses, along with some key themes from a series of regional meetings we held in 2023. UCB Pharma have provided funding for this initiative. UCB has not influenced or been involved in development of the content of the initiative.

Summary

We received responses from all 42 ICBs.

Twelve ICBs said they had no MSK lead. Of these, two said it was under review. The remaining ten had no lead.

Fourteen ICBs could not provide their priorities for MSK services. Of these, four said that this was under review. The remaining ten had no priorities.

This means that almost one in four ICBs have no lead for MSK and almost one in four have no priorities for MSK. Over one in three (16) have either no lead or no priorities.

We conclude from this that too many ICBs are giving insufficient attention to the MSK services they oversee and commission to comply with their statutory duties (see page 10 for details).

MSK is the leading cause of years lived with disability and one of the two leading causes of people being unable to work due to ill health. MSK cuts across primary, community and several secondary care specialties. ICB spend on these services is significant. MSK conditions represent a high proportion of people waiting for treatment, particularly in community services. Given its impact and cost to individuals, the NHS and the economy, MSK should be firmly on the agenda of every ICB.

Recommendation

Every ICB which has not explicitly discussed MSK services at a Board meeting in the last year should ensure that such a discussion takes place in order that the Board can understand the effectiveness of the services they oversee and commission, and the work that is required to ensure equitable access and outcomes for the population. This should also include consideration of children and young people with MSK conditions.

1. Why we focus on ICBs

ICBs are NHS organisations responsible for planning health services for their local population. They manage the NHS budget and work with local providers of NHS services, such as hospitals and GP practices, to agree a joint five-year plan.

The ICB statutory duties include:

- Duty to commission health services necessary to meet the reasonable requirements of the people for whom it has responsibility.
- Duty to secure improvement in the quality of services.
- Duty to reduce inequalities in access to and outcomes of health services.
- Duty to promote integration of health services.

MSK conditions are the largest cause of years lived with disability and the second largest cause of long term absence from work. Given the significance of MSK for the NHS, the economy and people's ability to live healthy and independent lives, we would expect the organisations responsible for planning health services for their population to have MSK on their agenda.

At the time of carrying out the requests, there was an additional reason for ICBs to consider MSK. The Government was preparing a Major Conditions Strategy. The interim report set out six major conditions, of which one was MSK. This document set out how the government saw the leadership required to deliver the strategy. This included "We are also looking to ICSs to develop, drive and deliver care that supports the objectives and ambitions of the major conditions strategy, including by incorporating the aims of the strategy into future joint forward plans set out by ICBs". Just one of the ICBs referenced the Major Conditions Strategy in their answers. The driver for the Major Conditions Strategy was the impact on the economy of long term ill health. MSK is one of the biggest causes of inability to work due to ill health, an issue that is equally high on the agenda of the new government. It will be impossible to address this unless the NHS at local and system level responds to this national priority.

2. Responses to our FOI requests

We received a response to our FOI from all 42 ICBs.

Of these, one answered only question 1 to say they had no MSK lead. All the others responded to all the questions.

2.1 Priorities for MSK

Fourteen ICBs could not provide their priorities for MSK services. Four said that this was under review. The remaining ten had no priorities.

Seven said there were no priorities. One of these cited the fact that MSK is not in the Core20PLUS5 conditions as the reason.
Three listed priorities so vague or high level that they could not meaningfully be considered priorities.
Four said that priorities were under review.

Analysis of responses

The remaining ICBs sent answers of varying detail and breadth. They were very varied in their approach, so it has been necessary to attempt to cluster responses around themes. The analysis below gives some indication of the range of responses.

MSK services span the whole system. They include primary, community and a number of secondary specialties. These are interrelated and attempts to address issues in silos are likely to move the problem to another part of the system rather than solve it. For instance, increasing orthopaedic capacity without a corresponding increase in rehabilitation will lead to pressures elsewhere in the system and/or poor patient outcomes.

Evidence of system wide approaches

- Three ICBs referred to ongoing MSK transformation.
- One talked about system wide integrated MSK services.
- Three gave quite comprehensive responses covering a range of different areas.
- One talked about a new service model, which is being led by the Trust.

Evidence of more specific priorities

- Twenty eight ICBs listed specific areas of focus, varying in their breadth and number.
- Six ICBs identified just a single priority (3 waiting, 1 pathways, 1 digital, 1 interface services).
- Pathways were mentioned by 13 ICBs – variously primary care, orthopaedic, rheumatology, physiotherapy, hip & knee, spinal, falls, fractures & osteoporosis, and end to end MSK.
- Waiting was mentioned by 10 ICBs – including community, trauma and orthopaedic and waiting times generally.
- Three mentioned support while waiting/prehab.

Specific conditions or specialties mentioned

Pain	6
Rheumatology	6
Community/Physio Services	7
Orthopaedics	3
Spinal	3
Fracture Liaison Service/Osteoporosis	3
Cauda Equina Syndrome	2
Mental Health	1
Fibromyalgia	1

Themes

Personalised Care/ Shared Decision Making	6
Self Management/Living Well/ Social Prescribing	4
Equalities/Equity of Access	4
Self Referral	3
Prevention	3
Data	3
Digital	2
Interface Services	1
Patient Engagement/ Co-Production	1

2.2 MSK lead

- Of the 42 ICBs, 12 did not identify a lead for MSK.
- Ten said they had no MSK lead.
- One said they had no single lead but this was under review.
- One was undergoing a restructure so could not answer.

Of the 30 who did identify one or more lead:

The most senior job title was:	
Director	9
Head of	6
Clinical Lead	3
Senior Manager/ Manager	4
Chair of MSK Network	2
Chief Medical Officer	2
A Senior Responsible Officer	2
MSK Programme Lead	1
Chief Operating Officer	1

Where MSK sits i.e. where the lead person works:	
Planned or elective care	11
MSK service	6
Clinical directorate	4
Operations	2
Integrated care	1
Hospital commissioning	1
System transformation	1
Programme delivery	1
Special projects	1
Unclear	2

Are the leads funded?

- Eight ICBs had one or more MSK clinical leadership roles funded.
- One specified that this was one session per week.
- Two said that at the time of answering this was only guaranteed to the end of the year (April 2024).
- All the others had MSK leadership included in a role that was not exclusively MSK.

MSK leadership commentary

To be effective in co-ordinating work on MSK improvements across an ICB, a person requires:

- Sufficient seniority to be able to make an impact outside the MSK services. This might be through an MSK lead getting support from someone with a more senior role. A number of ICBs mentioned more than one person with an MSK leadership role. Two had a senior person with a broad remit alongside one or more MSK leads.
- Sufficient time to devote to this work, in other words not being expected to manage an MSK service and be the lead without some recognition of the time required.
- Sufficient focus on MSK across the system. The risk of identifying MSK leadership in a very senior role is that they are not able to devote sufficient focus on MSK.

Children's MSK

When asked if the MSK lead identified covered adults only or also children:

- Fifteen said adult.
- Twelve said both.
- Three gave mixed answers e.g. varies by locality or adults and children with simple MSK conditions.

3. ARMA regional meetings

ARMA held four regional meetings during 2023. These were attended by anyone who chose to attend, including healthcare professionals, patient organisations and people with lived experience. They were self selecting and the health care professional attendance was heavily skewed towards community MSK services.

Each regional meeting included breakout groups by ICB area. There were sufficient attendees to have a meaningful discussion in relation to 11 ICBs. Breakout groups were asked to discuss the challenges they faced in MSK health, the priorities in their local ICB area for action and the potential solutions.

The outcomes of this highlight why ICB attention is required. Issues related to consistency of provision across the area, joined up working across the system, collaboration and an end to siloed working, were identified by seven of the eleven groups.

Three groups mentioned an MSK Network, group or community of practice as something which would support progress. (Some areas already have this in place.)

Priorities for improvement

Themes identified	Number of ICB groups identifying
• Workforce including retention and difficulties recruiting.	4
• Standardising provision. Have patients always had conservative management before referral? Is there parity in what is available across the region or between different GP practices? • Transition from primary to secondary. Supporting workforce to understand whole pathway form primary to secondary and how to support patient's journey. Ensuring joined up pathways. Referral triage bouncing around the system. Processes vary between Trusts. Blocks in system e.g. knowing if people are on the right waiting list. Primary and community using same approach to triage and needs based assessment. • Silo working (e.g. separate MSK and orthopaedic clinical groups). Individual providers not collaborating. Culture change to working in integrated systems rather than traditional service specific approach. • Support for persistent pain/Fibromyalgia.	3
• Tackling health inequalities – deprived areas and protected characteristics. • Ensuring rheumatology included in MSK. Rheumatology pathways. • IT systems not joined up and don't support advice and guidance. • Improving consistency of messages. Patient information needs to be up to date and accessible to the different audiences (spoken languages and education level). • Digital exclusion/literacy.	2
• Collaborate with other ICBs. • Need a long term vision for commissioning. • Approach still too medicalised. • Prevention. • Look at outcomes – population health measures. • Support for people waiting. • Self referral. • High DNA rates. • Lack of data in primary and community.	1

Enablers - what support people would like

Themes identified	Number of ICB groups identifying
• MSK Network/group/community of practice	3
• Collaboration across the ICB. Communication strategy to enable this. • Ability to signpost to patient organisations for self management and peer support. • Increasing collaboration working as an ICB together. • Relationship building and information sharing outside professional subgroups.	2
• Training opportunities. • Ability to benchmark our data with national data. • Minimum standards for persistent pain management. • Spinal MDT that is consistent across the patch. • Resource to support MSK leadership. • Reportable MSK targets. • Unified digital system.	1

4. Conclusion

Many ICBs are not giving sufficient attention or priority to MSK services they oversee and commission to comply with their statutory duties.

Duty to commission health services necessary to meet the reasonable requirements of the people for whom it has responsibility

Given the impact of MSK on the population, availability of high quality MSK services across the population is not given sufficient prominence by many ICBs. **Yet 10 out of 42 ICBs, almost 25%, have no MSK lead. Ten have no MSK priorities.**

Duty to promote integration of health services

Eight out of 42 ICBs gave answers that indicated a broad, integrated or transformative approach to their MSK priorities. Given the complexity of MSK services, spanning numerous secondary care specialties, community services, primary care and support from third sector organisations, an integrated approach is essential to improving services.

The frequency with which attendees at our regional meetings talked about siloed working and lack of join up between providers as key barriers to good quality MSK services, shows that this is an issue which should be a priority in many areas.

Duty to secure improvement in the quality of services.

Given the above findings, it is likely that many ICBs are failing in their duty to improve MSK services in their area.

This is not to say that no service improvement is happening. We hear of examples of innovation and improvement in local services. However, these are sometimes happening without the support of ICB leadership, indeed in some cases they are led by healthcare professionals working in their own time.

Many attendees at our regional meetings expressed frustration that they could see what needed to be done, but they were given little or no support to deliver.

Duty to reduce inequalities in access to and outcomes of health services.

ARMA's Act Now report into MSK health inequalities in MSK identifies the wide inequalities related to deprivation[i]. Versus Arthritis' The State of Musculoskeletal Health 2024 report shows inequalities related some protected characteristics[ii]. Every ICB has a lead for health inequalities. Yet many of these focus on the five conditions in the NHS England Core20PLUS5 approach, which do not include MSK. Indeed, one ICB told us they did not have any MSK priorities because it was not included in the Core20PLUS5.

The ICB duty is not restricted to Core20PLUS5 and the Core20PLUS approach can, and should, be applied to MSK. The recommendations in the report have had a warm reception from MSK services across England. However, many could achieve far more if they had the support of the ICB and the ICB equalities leads. Again, the picture is that of enterprising services working hard to deliver initiatives aimed at reducing inequalities with sometimes little support or join up.

5. Recommendation

Every ICB which has not explicitly discussed MSK services at a Board meeting in the last year should ensure that such a discussion takes place in order that the Board can understand the effectiveness of the services they oversee and commission, and the work that is required to ensure equitable and excellent access and outcomes for the population. This should include consideration of children and young people with MSK conditions.

[i] Act Now: Musculoskeletal Health Inequalities and Deprivation Report of ARMA's inquiry, March 2024
[ii] The State of Musculoskeletal Health 2024, Versus Arthritis

About ARMA

The Arthritis and Musculoskeletal Alliance (ARMA) exists to improve MSK services. We are a membership organisation which brings together patient, research and healthcare professional organisations working in MSK health. Working together as an alliance we have a powerful voice to influence policy and improve standards of care across the UK.

ARMA Members

Arthritis Action
BackCare
British Association of Sport and Exercise Medicine
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British Chiropractic Association
British Dietetic Association
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National Axial Spondyloarthritis Society
National Rheumatoid Arthritis Society & JIA
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Royal Osteoporosis Society
Scleroderma and Raynaud's UK
Society of Musculoskeletal Medicine
The Society of Sports Therapists
UK Gout Society
Versus Arthritis

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