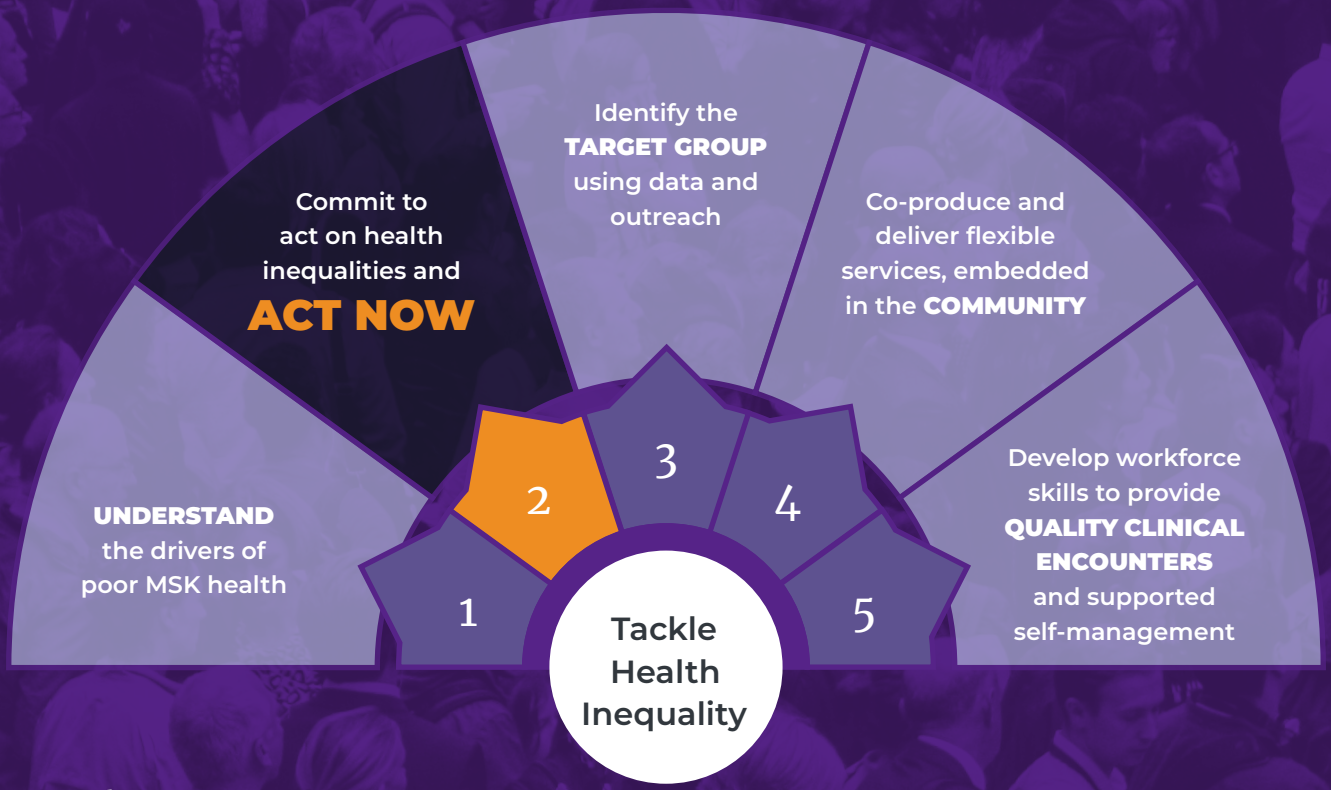
Act Now: Musculoskeletal Health Inequalities and Deprivation Summary

Summary for Northern Ireland

Report of ARMA's inquiry Summary, September 2024



Introduction

Musculoskeletal (MSK) conditions cover a broad range of health conditions affecting the bones, joints, muscles and spine. Common symptoms include pain, stiffness and a loss of mobility and dexterity. MSK health is fundamental to our wellbeing and impacts on every aspect of life, including work, learning, caring for family, travel and leisure, exercise, sport and living independently.

Throughout 2023, ARMA carried out an inquiry into inequalities in MSK health related to deprivation. We gathered written and oral evidence across the UK, including from MSK services that were undertaking work to address these inequalities. This inquiry did include Northern Ireland, but due to a lack of MSK-specific data, the findings in this summary are based largely on UK-wide evidence, nuanced through conversations with Northern Ireland clinicians and local data about health inequalities.

Financial support was provided for this project through sponsorship from Grünenthal UK Ltd and charitable grants from Pfizer Ltd, Novartis Pharmaceuticals UK and Janssen.

This document is a brief summary of the findings.

Use the QR code to access the full report, which includes recommendations for action, case studies and resources to help MSK health services, MSK health care professionals and health systems understand and address these inequalities.

Key messages from the inquiry

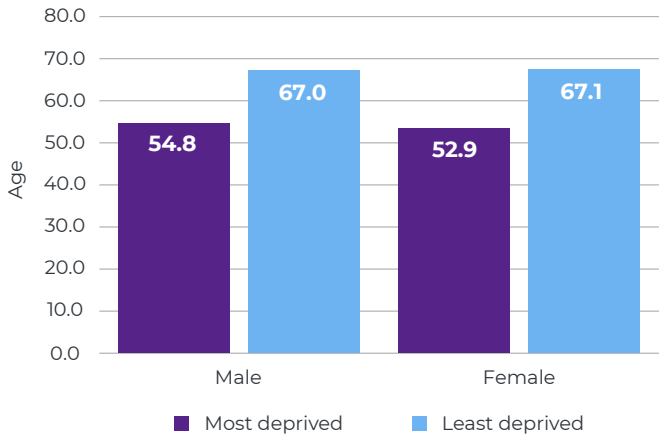
People with MSK conditions living in areas of deprivation experience health inequalities.

People in deprived areas across England, Wales and Scotland develop MSK conditions earlier than those in less deprived areas and are more likely to have multiple conditions and therefore to be clinically complex. As Marmot[i] stated, there is no biological basis for these disparities – they are avoidable. With sufficient commitment and focus, there is a real opportunity for healthcare services to push the dial back in the right direction.

In Northern Ireland, the gap in healthy life expectancy between the most and least deprived is 12.2 years for men and 14.2 years for women. MSK conditions will be a significant contributor to this, but existing data do not allow the type of analysis we have for the other UK nations. There is no reason to think that this will not be reflected in the MSK health of the population. However, without adequate data it is difficult to know how best to target efforts to reduce inequalities.[ii]

Healthy Life Expectancy

Source: Health Inequalities Annual Report 2024(ii)



Health inequalities are largely driven by the wider determinants of health.

Only 20% of our health and health inequality relates to healthcare. This report identifies the most significant social and economic factors influencing poor MSK health: poverty, education, employment and an environment and food culture that deters physical activity and a healthy diet. Therefore, whilst there is a significant amount that the NHS can do, it cannot alone eliminate inequalities in MSK health.

i Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, et al. The Marmot review: Fair society, healthy lives. London; 2010.

ii Health Inequalities Annual Report 2024, Information Analysis Directorate, Department of Health and Northern Ireland Statistics & Research Agency.

People with MSK conditions from areas of deprivation often lack the 'bandwidth' to manage their condition effectively when they are more concerned with putting food on the table or heating their home. Understanding the many competing pressures people face while trying to manage their MSK condition is important for people working with individuals with MSK conditions from deprived areas. If they are to tackle MSK health inequalities, MSK services and MSK healthcare practitioners need to be mindful of this wider context.

The NHS can help to reduce health inequalities.

The inquiry heard from service managers and health professionals who had taken steps to address health inequalities. This report contains case studies showing how they have approached this and recommendations based on what we heard.

- **Getting closer to and knowing your community.** Moving services into community spaces such as local council gyms, church halls and community centres can make them more accessible to under-served groups from deprived areas. We also heard of services that place a high value on employing people from the local community to allow patients to see themselves reflected in the service and guarantee that professionals know the local facilities and services.
- **Developing shared ownership of services through engagement and co-production.** Some services have found innovative ways to engage with under-served groups. Health professionals have volunteered at foodbanks and homeless cafes to get closer to, and build trust with, groups that have either not accessed services at all or have had negative experiences of unresponsive one-size-fits-all services.
- **Using data to identify, tackle and monitor barriers to access and unequal health outcomes.** Analysing data allows services to identify unmet need – including where people from areas of deprivation are under-represented. However, this is not always easy. Service managers talked about the difficulties of collecting, accessing and integrating sources of data.
- **Avoiding inertia caused by the scale of the problem and starting now in the spirit of service improvement.** The overriding message from the health professionals who gave oral evidence to this inquiry was for MSK service leaders and managers not to wait for perfect data and instead to act now based on what services already know. Start small with an intervention aimed at improving the service by reducing inequality of access or outcomes experienced by people with MSK conditions from areas of deprivation.

A drop-in podiatry service in shelters for people experiencing homelessness provides MSK care to this underserved group. People who take up the offer of a podiatry service are more likely to see other health professionals. They will often discuss other health concerns, giving the opportunity to signpost them to other health services.

- **Paediatric MSK services face particular challenges in identifying and tackling health inequalities.** Paediatric MSK services in Northern Ireland are based in Belfast. The inquiry heard about the challenges facing those in more deprived areas in taking children to appointments with the associated need to take time off work, especially if they need to use public transport. Services can support patients from areas of deprivation through effective and age-appropriate engagement, the willingness to provide services as flexibly as possible, and by offering intensive support where needed to children and young people facing the most significant challenges.
- **Targeting intensive and tailored supported self-management where need is greatest.** Supported self-management strategies, including health coaching, peer support and social prescribing, are required for those facing challenging social situations or lacking in health literacy and/or digital access. These should be embedded in MSK pathways with priority given to those most in need.
- **Recognise the impact of managing other long term conditions alongside MSK.** Where people live with multiple conditions, these conditions interact. Poor MSK health can lead to worsening of other conditions, which in turn make managing MSK more challenging. Healthcare professionals need to consider the impact of this and avoid adding to the burden of managing multiple conditions.
- **The quality of clinical encounters must be at the heart of services' approach to people with MSK conditions living in deprivation.** Services that want to work more effectively with people with MSK conditions living in deprived areas must invest in staff training to improve the quality of all clinical encounters. Health professionals need the skills to accurately assess an individuals' understanding and capacity to manage their condition, whilst maintaining awareness of the competing priorities an individual may have. This is particularly important for people from areas of deprivation with multiple conditions.

"I would like to feel that someone actually listens to what I'm saying, what pain I have, what treatments I can't take due to having caring responsibilities... no one actually opens their ears and listens."

Person with lived experience

Summary of recommendations

This is a summary of the recommendations. Please see the report for a full list of recommendations and resources to support implementation.

Leaders and managers of MSK services should

- Identify the inclusion health groups in their area and develop a tailored offer for these groups including flexible, drop-in services, and partnerships with voluntary or community organisations.
- Recognise the value Voluntary, Community, Faith and Social Enterprise (VCFSE) groups working with disadvantaged and marginalised groups can bring.
- Identify communities that are not accessing the service and find ways to engage them.
- Ensure that any change in service design or quality improvement work is co-produced with people with lived experience.
- Advertise roles in MSK services to encourage as many applicants as possible that reflect the population of the area served.
- Use available data to tackle health inequalities.
- Develop an action plan to understand the reasons for and remove any barriers faced by patients.
- Ensure that the service provides supported self-management to individuals with MSK conditions living in areas of deprivation.
- Prioritise people with co-morbidities living in areas of deprivation for supported self-management.
- Ensure that all healthcare professionals receive training in health inequality, health behaviour change, health coaching, multi-morbidity management and how to address issues related to activity, weight, diet and nutrition.
- Ensure all communications are accessible to people with low levels of health literacy.
- Ensure that where digital resources or tools are provided by the service, an alternative means of access must be available for those who cannot easily access digital resources.

Leaders and managers of Paediatric MSK services should

Address all of the above and...

- Ensure that the service offers flexible appointments outside of school hours and/or drop-in clinics.
- Offer 'one-stop-shop' clinics or grouped appointments – combining appointments of different specialties and therapies.
- Provide paediatric therapies such as occupational therapy, physical therapy and psychotherapy through local rehabilitation hubs rather than in tertiary centres.
- Ensure provision of advocacy or health navigator support for children with MSK conditions who do not have effective family support with the resources to drive their care.

MSK health professionals should

- Be aware of deprivation and its impact when seeing patients.
- Understand that trust may need to be rebuilt between services and people with MSK conditions living in deprived areas.
- Employ the strategies set out in the supported self-management toolkit.[iii]
- Consider co-morbidities and avoid adding to the burden people face in managing them.
- Be aware of resources locally to support people living with food insecurity so that they can refer as required.
- Address modifiable risk factors with those in most need through a supported self-management and health coaching approach.
- Consider health literacy and digital exclusion in their clinical encounters and provide additional support as needed.

Local health systems should

- Make local data on health inequality and deprivation available to all MSK services to support work to address health inequalities.
- Analyse the distribution and location of MSK health services, including those for children and young people.
- Consider how to address access needs of those who find travel difficult due to cost or location.
- Locate paediatric MSK rehabilitation hubs in areas of deprivation to aid access to care.
- Agree a shared strategy for provision of a range of supported self-management services (in line with the toolkit for MSK supported self-management) targeted at deprived areas.
- Be aware of the impact of food insecurity on their local population and work with local partners to mitigate this as well as seeking solutions to the underlying causes.
- Work with clinicians to agree better routes for collecting and utilising MSK data to inform service improvements and patient care.

iii Supported Self-Management in Musculoskeletal Services see https://arma.uk.net/resources/

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.

Current ARMA membership

Arthritis Action, BackCare, British Association of Sport & Exercise Medicine, British Association of Sport Rehabilitators, British Chiropractic Association, British Dietetic Association, British Orthopaedic Association, British Society of Physical & Rehabilitation Medicine, Chartered Society of Physiotherapy, CCAA Kids with Arthritis, Cornwall Arthritis Trust, Ehlers Danlos Support UK, Faculty of Sport and Exercise Medicine, Fibromyalgia Action UK, Gloucestershire Arthritis Trust, Hypermobility Syndromes Association, Institute of Osteopathy, McTimoney Chiropractic Association, Musculoskeletal Association of Chartered Physiotherapists, National Axial Spondyloarthritis Society, National Rheumatoid Arthritis Society & JIA, Orthopaedic Research UK, Pain Concern, Physiotherapy Pain Association, Podiatry Rheumatic Care Association, Primary Care Rheumatology Musculoskeletal Medicine Society, Psoriasis Association, Rheumatology Pharmacists UK, Royal College of Chiropractors, Royal College of Nursing Rheumatology Forum, 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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