

Standards of Care
for people with

Osteoarthritis



Contents

The background	1
About the Standards	3
The Standards of Care	
Standards to improve access to information, support and knowledge	5
Standards to improve access to the right services that enable early diagnosis and management	7
Standards to improve access to ongoing and responsive treatment and support	12
Glossary	15
Appendix: Developing the Standards	16
Acknowledgements	16
Bibliography	19

ARMA is the umbrella organisation for the UK musculoskeletal community. ARMA is a registered charity No 1108851. Our member organisations are:

- Arthritis Care
- Arthritis Research Campaign
- BackCare
- British Chiropractic Association
- British Coalition of Heritable Disorders of Connective Tissue
- British Health Professionals in Rheumatology
- British Institute of Musculoskeletal Medicine
- British Orthopaedic Association
- British Scoliosis Society
- British Sjögren's Syndrome Association
- British Society for Paediatric and Adolescent Rheumatology
- British Society for Rheumatology
- British Society of Rehabilitation Medicine
- Chartered Society of Physiotherapy
- Children's Chronic Arthritis Association
- CHOICES for Families of Children with Arthritis
- Early Rheumatoid Arthritis Network
- Lupus UK
- Manipulation Association of Chartered Physiotherapists (UK)
- Marfan Association (UK)
- National Ankylosing Spondylitis Society
- National Association for the Relief of Paget's Disease
- National Association of Rheumatology Occupational Therapists (NAROT)
- National Osteoporosis Society
- National Rheumatoid Arthritis Society
- Podiatry Rheumatic Care Association
- Primary Care Rheumatology Society
- Psoriatic Arthropathy Alliance
- Raynaud's and Scleroderma Association
- Rheumatoid Arthritis Surgical Society
- Royal College of Nursing Rheumatology Nursing Policy and Practice Group
- Scleroderma Society
- Society for Back Pain Research

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The contents of this document and further resources including contact details for our member organisations, further information about our work and this project, including additional examples of good practice and resources to support implementation are available on the ARMA website at www.arma.uk.net

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Osteoarthritis – the size of the problem

Osteoarthritis is the commonest form of arthritis. It affects mainly the knee, hip, hand, spine and less often, the feet. It is characterised by joint damage and joint failure, as the process of the disease causes damage to cartilage and the growth of new bone in affected joints, causing stiffness and pain.

At least 4.4 million people in the UK have X-ray evidence of moderate to severe osteoarthritis of their hands, over 0.5 million have moderate to severe osteoarthritis of the knees and 210,000 have moderate to severe osteoarthritis of the hips.^[1] It is difficult to define where joint pain ends and arthritis begins, and many more people who do not have a firm diagnosis of osteoarthritis are also affected by joint pain – recent estimates suggest up to 8.5 million people in the UK.^[2]

Osteoarthritis affects more women than men, and tends to affect people as they get older but is also common amongst people of working age. Nearly one in five women over 60 has osteoarthritis.^[3] The number of people with osteoarthritis in the UK is increasing as the population ages, and as the prevalence of obesity, a risk factor for osteoarthritis, also continues to rise.

What is the impact of osteoarthritis?

Osteoarthritis is the most common cause of disability in the UK. It reduces movement in the affected joints and often causes significant limitations in everyday activities. Many people with osteoarthritis experience persistent pain.^[4] It can affect every aspect of a person's daily life, and overall quality of life.^[5]

Osteoarthritis of the large joints reduces people's mobility, and can make it difficult or impossible to climb stairs or walk, for example. Osteoarthritis in small joints such as the hands and fingers makes many ordinary tasks difficult and painful.

The costs of osteoarthritis to the NHS are high. Every year over 2 million people consult their general practitioner (GP) with symptoms due to osteoarthritis; there were over 114,500 hospital admissions in 2000-2001.^[6]

Osteoarthritis has a significant negative impact on the UK economy, with its total cost estimated as equivalent of 1% of gross national product (GNP) per year.^[7] Around 36 million working days are lost each year because of osteoarthritis, costing the economy £3.197 billion in lost production.^[8]

Why we need Standards of Care

There is evidence that many people with osteoarthritis in the UK are not receiving appropriate advice or care.^[9] Older people particularly may be more reluctant to seek medical help because of pessimism about the availability, effectiveness and risks of treatment like joint surgery.^[10]

Given the costs of osteoarthritis to the NHS and to national productivity, it is disappointing that there is no National Service Framework for osteoarthritis and other musculoskeletal conditions. This lack of priority is also reflected in the fact that joint pain and osteoarthritis do not feature in the Quality and Outcomes Framework of the current GP General Medical Services (GMS)



contract – despite the fact that people will receive most of their care for these conditions in primary care.

Nevertheless, there is good evidence about the effectiveness of treatments, and simple interventions can be beneficial. Moreover, despite the lack of priority and resources attached to osteoarthritis services, health services in some parts of the country have identified innovative ways of improving the care they provide to people living with these conditions. These Standards bring together existing evidence and best practice. They set out a framework for services which really meet the needs of the many people living with osteoarthritis and joint pain.

Implementation of these Standards should:

- improve prevention and effective treatment of osteoarthritis, leading to better quality of life for the millions of individuals who are affected and their carers
- identify for people with osteoarthritis and joint pain the care and treatment they can expect
- significantly reduce the costs to the NHS, for example from preventable disease and avoidable admissions to hospital. There is evidence, for example, that much large joint osteoarthritis could be prevented if people could be encouraged to adopt healthier lifestyles
- improve productivity and reduce the benefits bill by enabling people to stay active and reduce the number of working days lost to illness
- promote consistent approaches to advice and treatment.

1 Arthritis Research Campaign (2002)

2 Arthritis Care (2004)

3 Woolf AD and Pfleger B (2003)

4 Arthritis Research Campaign (2002)

5 Doherty M et al (2003)

6 Arthritis Research Campaign (2002)

7 Levy E et al (1993); Doherty M (1994); Doherty M et al (2003)

8 Department for Work and Pensions. Analytical Services Division; cited in: Arthritis Research Campaign (2002)

9 Arthritis Care (2004)

10 Sanders C et al (2004)

ARMA's Standards of Care for people with osteoarthritis are intended to support people of all ages with osteoarthritis to lead independent lives and reach their full health potential through:

- access to information, support and knowledge that optimise musculoskeletal health for everyone and enable self-management
- access to the right services that enable early diagnosis and treatment
- access to ongoing and responsive treatment and support.

The Standards define what services are appropriate under these three themes and suggest ways of providing them effectively, and in a measurable way, in the form of key interventions. A detailed rationale for the Standards draws on available evidence and examples of good practice drawn from ARMA's ongoing call for good practice: a database giving details of these and other examples is available at www.arma.uk.net.

The Standards are not guidelines, or algorithms of care, though they refer to these where available.

The Standards of Care for people with osteoarthritis form part of a suite of Standards; other Standards published to date are for inflammatory arthritis and back pain. Further Standards, for bone disease, soft tissue rheumatism and connective tissue disorders, are planned for 2005.

The Standards acknowledge the fact that those planning and delivering services around the UK face differing demographic, geographic and economic factors, which will affect how the Standards are implemented in each locality. We hope the Standards will act as a tool for all stakeholders - service users, providers, commissioners and policy-makers - to work together to review and improve their local musculoskeletal services.

Key principles – the user-centred approach

The project has been driven by the needs of people living with musculoskeletal conditions. It began with the establishment of a set of key principles for care, developed by a group of people living with musculoskeletal conditions and consulted upon widely. These principles have underpinned the development of each set of condition-specific Standards.

The key principles, which can be found on ARMA's website www.arma.uk.net, affirm that 'patients' are individuals who need different types of advice and support at different times; and who need integrated services providing advice and support that cover all aspects of managing and living with the condition – clinical, personal, social and employment/education.

In particular, the Standards recognise that health services play a key role in supporting people to maintain or return to employment or education.

Nevertheless, while these standards focus on health services, it must be recognised that people with osteoarthritis and other musculoskeletal conditions have wide-ranging needs. Social care often plays a key role in ensuring people can remain as active and independent as possible. Factors such as access to transport and the built environment may have a major impact on quality of life. More work is needed to understand and meet these needs.

Musculoskeletal conditions affect families and carers as well as individuals. Indeed, many people with these conditions may be carers themselves. The Standards do not make specific recommendations on issues relating to carers: this also needs to be the subject of further work to ensure that carers' needs are understood and addressed.

How the Standards were developed

The Standards of Care for people with osteoarthritis were developed by an expert working group, facilitated by ARMA. The group included people with osteoarthritis, representatives of user organisations, experienced service providers and experts from many professions, from around the UK. Starting with a review of the needs of people with osteoarthritis, the group met five times between September 2003 and June 2004 to determine evidence-based Standards to meet those needs, consulting widely and publicly on the drafts. The Acknowledgements on page 16 give details of the working group membership.

Clinical experts have identified the evidence base, including relevant guidelines for the management of osteoarthritis. References are shown as footnotes in the Standards. Evidence has not been graded for the purposes of this document. For further details on the evidence base, please refer to the references quoted in the document.

The resulting Standards are therefore based firmly on the experiences and preferences of people with osteoarthritis, and on evidence and good practice where this is available. The working group plans to review these Standards in 2007, or sooner if there are significant developments in care for people with osteoarthritis.

Next steps

The publication of these Standards is the beginning of an ongoing programme involving the whole community to improve musculoskeletal services.

We are circulating the Standards widely to people with musculoskeletal conditions, doctors, allied health practitioners, providers and commissioners of health services, voluntary organisations and policy makers. We will publish audit tools to support the Standards' implementation. We are also collecting and sharing examples of good practice, which are accessible to everyone through our online database.

We invite all stakeholders to make a commitment to implementing the Standards. First steps might be to:

- audit existing services
- identify champions for change in musculoskeletal services, and set up a working group to develop your local strategy and priorities
- work in partnership with all stakeholders, including national and local voluntary organisations, to involve service users in designing and developing services.

Above all share your success! Tell us about your initiatives; send us examples of good practice; help to build a national resource for high-quality musculoskeletal services.

Prevention

Standard 1

Health and community services should make information available to the public on lifestyle choices that promote good musculoskeletal health and reduce the risk of developing joint pain and osteoarthritis. This should include information on physical activity and exercise, weight control, good nutrition and prevention of injuries.

Information and support to self-manage

Standard 2

Health and community services should provide information, education, and support to enable people to identify signs and symptoms of joint problems and osteoarthritis, and information on how to manage joint pain and remain active, and when to seek professional advice.

Information to enable choice

Standard 3

People with osteoarthritis should have access to information to enable them to make informed choices about service providers, the treatments they offer and the facilities available.

The rationale

- There is evidence that lifestyle alterations reduce the risk of developing joint pain and osteoarthritis and alleviate joint symptoms and disability, in particular: the promotion of strengthening exercises^[11]; general (aerobic) fitness^[12]; weight reduction programmes for the overweight and obese^[13]; and the use of appliances (sticks^[14], insoles^[15], braces^[16]). Up to half of all knee osteoarthritis is theoretically preventable by weight reduction and up to a third is preventable by following advice about joint protection when taking part in activities that could lead to joint injury and development of osteoarthritis.^[17]
- More public awareness of musculoskeletal conditions can help people with symptoms and signs of joint problems, such as osteoarthritis, to manage these effectively and to seek professional advice appropriately. Healthcare professionals, including pharmacists, play a valuable role in signposting individuals to appropriate support and advice.
- Self-management alone may be sufficient for many people, provided they can get information on how to manage symptoms and exercise effectively, and understand when it is necessary to seek medical advice. There is evidence that promoting self-management strategies helps people to manage the unpredictable course of joint pain and osteoarthritis.^[18]
- People with joint pain and osteoarthritis should be regarded as equal and active partners when it comes to making decisions about their healthcare. In order for people to become active partners in their own care, they need to be well informed about their condition, empowered to take responsibility for their musculoskeletal health, and able to make informed choices about treatments, providers and settings for care.



Putting the Standards into practice: key interventions

- i Health and community services and other providers, such as pharmacies, educational establishments and voluntary organisations, should make information available to the public on lifestyle choices that reduce the risk of developing joint pain and osteoarthritis. This should include information about:
 - physical activity and exercise
 - general (aerobic) fitness
 - weight reduction programmes
 - preventing injuries.
- ii Health services should promote self-management strategies for people with joint symptoms, including information and advice about:
 - how to improve general musculoskeletal health
 - physical activity and exercise, for example quadriceps exercises for knee pain
 - self-management of symptoms, including identifying initial signs and symptoms
 - steps to reducing pain and staying mobile
 - what action to take if symptoms worsen
 - when, how and where to seek professional advice.
 Facilities and support should be available in the community to help people to exercise and improve their musculoskeletal health.^[19]
- iii Health agencies should make appropriate information available on the range of treatments and management options, providers and settings for care.^[20]
- iv Healthcare providers/commissioners, social services, voluntary sector and leisure services should develop partnerships to deliver seamless comprehensive services to support people with osteoarthritis.

good practice A

Good Practice Example - A

A voluntary organisation provides public information stands for people with arthritis, staffed by trained volunteers who have arthritis themselves. The main aim of the project is to provide relevant and reliable information to members of the public at a location that is frequented by people with arthritis, their families and carers. Information points are maintained at accessible venues relevant to people with arthritis such as rheumatology and orthopaedic clinics, physiotherapy and occupational therapy departments, GP surgeries and hospital foyers etc.

v Information should be accurate, consistent, clear and accessible. It should be available in a variety of formats and in different languages where appropriate.

vi **Developmental:** Information and initiatives about lifestyle choices should be targeted to reach people more at risk of joint pain and osteoarthritis, such as older people. They should involve community health professionals; for example, community pharmacists.

11 Minor MA (1999)
 12 Kovar PA et al (1992); Ettinger WH et al (1997)
 13 Felson DT et al (1992); Messier SP et al (2004)
 14 Rogers JC and Holm MB (1992)
 15 Hewett T et al (1998)

16 Hewett T et al (1998); Crenshaw SJ et al (2000)
 17 Felson DT and Zhang Y (1998)
 18 Barlow JH et al (2000); Bodenheimer T et al (2002)
 19 Hurley MV (2002)
 20 E.g. booklets from www.arthritiscare.org.uk; www.arc.org.uk

Identifying warning signs

Standard 4

People with symptoms of joint pain and/or osteoarthritis should have access to health professionals in primary care and the community. These professionals should be trained to make a diagnosis, to identify warning signs of serious disease and to make appropriate and timely referrals to specialist care.

Developmental: People with joint pain should have individual assessments of their musculoskeletal health in primary care, taking into account factors such as age and co-existing conditions.

Individualised care plans

Standard 5

On diagnosis people should be offered a care plan giving constructive messages about their condition.

Developmental: People with joint pain and/or a diagnosis of osteoarthritis should have access to a health worker, who can work with them in developing an individualised care plan and in making informed choices about treatments, providers and services.

Pain relief

Standard 6

People with joint pain and/or a diagnosis of osteoarthritis should be offered a choice of symptomatic pain relief and pain management strategies. These should be in accordance with the best available evidence and national/international guidance and guidelines, including NICE guidance and referral protocols.

This should be supported by information about the benefits, risks and availability of treatment and management options, to help people make informed choices.

Interventions and therapies to restore independence

Standard 7

Where joint pain limits a person's capacity to carry out activities of daily life – in their work, hobbies or social activities – people should have access to a multi-disciplinary team to assess them and refer them for treatment or other services to help restore their independence.

Remaining active

Standard 8

People with joint pain and osteoarthritis should be encouraged to remain in work or education wherever possible. Vocational rehabilitation should be available to support people in staying in existing employment or finding new employment.

Referral for specialist care

Standard 9

People whose condition is not responding to treatment or who are experiencing worsening symptoms should be referred promptly to appropriate specialist care, in accordance with agreed protocols. This should be accompanied by information to support choice.

Surgical care

Standard 10

If surgery is recommended, people with osteoarthritis should be offered a multi-disciplinary pre-surgery assessment to provide information on the procedure and on post-operative care, to enable informed consent, and to agree an individualised discharge plan. Information should be offered to enable an informed choice of provider.

Involvement of people with osteoarthritis

Standard 11

Healthcare organisations should involve people with osteoarthritis in the planning and development of their services for osteoarthritis and other musculoskeletal conditions.



The rationale

- While many people at present visit their GP to report symptoms and gain advice and treatment, the GP should not be regarded as the only point of contact with the health service. Other healthcare professionals in primary care, such as physiotherapists or nurses, may also be able to offer more detailed advice and management. Community pharmacists are also key providers of information and advice.
- A diagnosis of osteoarthritis can be helpful for many people, as it recognises their experience, enables them to 'rule out' other conditions and can help them to self-manage.^[21] A diagnosis can be distressing if the person is left feeling that 'nothing can be done'; but, with effective management many people with osteoarthritis can enjoy a good quality of life and level of independence. People with a diagnosis of osteoarthritis need to be offered constructive messages about how they can manage their condition. It is not always possible or necessary to give an X-ray diagnosis of osteoarthritis^[22], and people with joint pain but without such a diagnosis should receive the same care.
- Osteoarthritis can affect all aspects of a person's life. Services should be designed to maintain and improve their quality of life, to enable them to be as independent as possible, to empower them to manage their condition effectively and to limit the impact of joint pain on their work and activities of daily life.
- There is strong evidence for the effectiveness of both pharmacological and non-pharmacological treatments.^[23] People should have access to appropriate pain management, in line with evidence-based guidelines.^[24] Pain management should allow the person to express their experience of pain, and allow time for assessment. People should receive guidance on how to administer pain relief themselves.
- People need to be able to make informed choices about treatments, healthcare providers and services. Involving individuals in decision-making and enabling informed choice can improve concordance (a person's adherence to a treatment plan). Health professionals need to support individuals in exercising choice.
- Self-management training is particularly important to help restore people's independence, build their skills to cope with their condition, and enable them to make informed choices about treatments. There is evidence that education programmes and support groups help people to self-manage their symptoms.^[25]
- Osteoarthritis is not just a medical diagnosis; people may have other health and social care requirements, including psychological support, which need to be recognised and evaluated.
- People need access to the full range of support in the community, including physical therapies and rehabilitation services. This includes: physiotherapy, occupational therapy, podiatry, as well as support from community pharmacy and social services. This is particularly important for older people with osteoarthritis, who may find it harder to get to hospital-based services.
- People may benefit from footwear assessment, assistive devices and adaptations to their home; for example grab rails, bath aids, gripping aids, lifts or stair elevators.

- In most cases, the services an individual needs to manage his/her osteoarthritis will be available in the community. Where a person requires specialist opinion or care, this should be readily accessible.
- Osteoarthritis affects many people of working age. With effective management and support, many people can stay in or return to work. Vocational rehabilitation needs to happen at the same time as medical rehabilitation, as evidence shows that few people return to work once they are receiving incapacity benefit.^[26]
- Where people are not able to work, they may need advice and support to enable them to access benefits and other services such as vocational re-training.
- It is vital that people with osteoarthritis who are offered surgery give informed consent. This means giving people both information and time to consider their decision.
- Experience shows that a full pre-operative assessment, involving the wider multi-disciplinary team, helps to ensure that people can be discharged rapidly and safely following their operation.
- Surgical treatment should be made in accordance with evidence based guidelines.^[27]

Putting the Standards into practice: **key interventions**

- vii People seeking help for joint pain and/or osteoarthritis should be offered management in accordance with current national/international evidence based guidelines e.g. European League Against Rheumatism recommendations.^[28]
- viii The primary care health professional should assess whether people need immediate specialist review. This should include screening for 'red flags' such as warning signs of serious disease,^[29] and signs of other conditions. People who need an appointment should be offered one within 13 weeks of referral or sooner if clinically indicated.
- ix People should be given a diagnosis if appropriate. This should always be given with positive and constructive messages, including written information about managing joint pain and advice on accessing additional support, e.g. from the GP or other health professionals, voluntary organisations, telephone helplines. This should form part of a care plan given to the person with osteoarthritis. The care plan should include:
 - information about the choice of treatments, care providers and services
 - information on how to self-manage
 - what to do if symptoms get worse
 - contact details for national and/or local support groups
 - information on pathways for ongoing care and treatment review (i.e. information about the care people can expect, and when; and when they will have a review of their treatment).
- x Treatments should be tailored to the individual and should take into account factors such as the person's age; co-morbidity (other coexisting medical conditions)^[30] particularly in older people; the severity of their joint pain; the person's own preferences; and the side effects of treatment.



- xi Treatment options should include education, exercise, pain relief (for example, with analgesics or anti-inflammatory drugs either locally or systemically), weight reduction (if the person is obese), and prescription of walking sticks and insoles. People should have information on the benefits and risks of treatments to enable them to make informed choices in line with their preferences.
- xii Treatment options should also include referral to health professionals such as occupational therapists, physiotherapists, podiatrists or other members of the multi-disciplinary team.
- xiii Clear pathways (routes through care and different services) need to be determined and configured by local services so that people can be referred between healthcare professionals as part of a community-based musculoskeletal service. GPs should be aware of healthcare professionals in primary care to whom they can refer people for in-depth advice and management, such as a physiotherapist or nurse. Healthcare providers could consider reconfiguring their services so that healthcare professionals other than GPs become the first point of contact for people with osteoarthritis and joint pain.

B good practice

Good Practice Example - B

Primary care organisations within a local health economy have set up multiprofessional orthopaedic triage teams. These are based in primary care with regular links to secondary care services. GPs can refer patients directly to the triage teams, enabling them to access rapid informed opinion on the care/treatment plan for their patients. There is a guarantee of no more than a six week wait from referral from a GP to the appointment with the team. A 30 minute appointment allows the patient to have an informed discussion about their diagnosis, treatment options and choices, and to be actively involved in planning their future care and treatment.

- xiv People whose condition is not responding to treatment should be referred to appropriate specialist care, which could be in a primary, intermediate or secondary care setting. People should be offered a choice of care providers where available, with appropriate information to help them make decisions about their care. Appropriate specialist care may include: nurse specialist; physiotherapist or GP with a special interest in musculoskeletal pain; rheumatology; rehabilitation; orthopaedic surgery.
- xv Healthcare organisations should ensure that there is access to training, on the needs and care of people with osteoarthritis, for all professionals involved in their support and care.
- xvi People with severe pain and disability should be assessed and considered for surgery and joint replacement. Information should be given on providers and settings for care, to enable people to make an informed choice. If a person wishes to be considered for surgery, she or he should be offered an opinion from a surgeon within 13 weeks of referral or sooner if clinically indicated.

- xvii **Developmental:** People should have access to a lead individual or specialist health professional who also has expertise in employment issues, who can help to 'bridge the gap' between people's health and employment needs.^[31]

- xviii **Developmental:** All people with osteoarthritis should have access to continuous and co-ordinated services and support – this may involve healthcare, social care, benefits, housing, transport and other service sectors.
- xix Health service providers should involve people with osteoarthritis in helping to plan and develop services at both local and national level.
- xx Advice should be available on modifying working practices and on adapting workplaces and educational establishments. People should have access to information on the steps that can be taken to support them. Employers should seek advice from various sources, for example from health professionals and government agencies, including Health & Safety Executive (HSE), access to work and disability employment advisors. For children and adolescents attending educational establishments, support and advice should be provided by special needs advisors and through the annual statementing process if this applies to the child/adolescent.

Developmental: Occupational health services, where available, should provide advice to employers.

- xxi Health services should provide access to vocational rehabilitation services.

i For further information and resources, including details of ARMA's member organisations and other examples of good practice and information on implementation, visit www.arma.net.uk

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- 21 Consensus of ARMA Working Group
 - 22 Peat GP et al (2001)
 - 23 Jordan KM et al (2003)
 - 24 Altman RD et al (2000); Jordan KM et al (2003)
 - 25 Barlow J (2001); Barlow J et al (2002)
 - 26 Department for Work & Pensions (2004)
 - 27 National Institute for Clinical Excellence (NICE) (Jul 2001a & b); NICE (Dec 2001a & b); British Orthopaedic Association
 - 28 Jordan KM et al (2003)
 - 29 Primary Care Rheumatology Society (1999); Peat GP et al (2001)
 - 30 Kadam UT et al (2004)
 - 31 British Society of Rehabilitation Medicine (2003)

Self-management and support

Standard 12

People with joint pain or osteoarthritis should have access to self-management programmes, including those led by lay people, throughout the lifetime of their condition.

Standard 13

Healthcare organisations should involve people with joint pain and osteoarthritis in the development of their services for musculoskeletal conditions.

Regular review of treatment

Standard 14

People with joint pain or osteoarthritis should be offered a treatment review at regular intervals.

Prompt access to care if symptoms worsen

Standard 15

If symptoms worsen, people with joint pain or osteoarthritis should have rapid access to health professionals trained to carry out specific care or treatment, and who can refer them to other specialist care if needed.

Developmental: People with complex conditions including co-morbidities and complications arising from their osteoarthritis or its treatment, and/or those in whom the condition has become very disabling, should have a key health worker in primary or secondary care who can enable the individual to access the full range of support services.

The rationale

- Every effort should be made to enable people with osteoarthritis to remain as independent as possible. Evidence suggests that people who are able to remain active and in work or education are better able to cope with their disease and have less depression.^[32]
- Evidence shows that approaches such as pain management programmes, exercise programmes and access to self-management programmes promote and help people to develop ways of coping with their condition.^[33]
- Research has shown that greater involvement of the individual in understanding, monitoring, reviewing and deciding their care needs is beneficial, particularly for people living with long term conditions.^[34] People who are more involved in their care may:
 - manage their condition more effectively
 - feel better
 - manage risks to their health more effectively
 - have less pain
 - be less depressed
 - use health services less.
- Studies have shown that educational interventions can provide significant benefits for people who have a range of chronic diseases.^[35] There needs to be wider recognition of the importance of self-management initiatives led by people with chronic conditions (such as the Expert Patient Programme) and support networks or self-help groups.
- People with joint pain and osteoarthritis should be involved in helping to shape services. People with musculoskeletal conditions should be involved in and consulted about the

development of healthcare policy and practice, at both a local and national level. Their perspective on service delivery can lead to imaginative solutions and improvements to healthcare services, helping services to meet people's real needs.

- There is evidence that specific treatment approaches are effective for people whose joint symptoms worsen. These include, for example, joint injection^[36] and acupuncture.^[37]
- People may need support in gaining access to services such as orthotics, wheelchair services, Environmental Control Services, podiatry and so on.

Putting the Standards into practice: **key interventions**

- xxii** Health services should support people in developing ways of coping with their condition by providing evidence-based strategies including: pain management programmes, exercise programmes and self-management programmes.
- xxiii** Health service providers should offer treatment review at appropriate intervals for people with osteoarthritis.
- xxiv** Developmental: Healthcare providers should proactively identify and contact people who may require treatment review.
- xxv** Health services should provide information on local and national voluntary organisations.
- xxvi** People whose symptoms deteriorate should have access to health professionals who can carry out specific interventions including pain management programmes, exercise prescription, joint injection or biomechanical assessment.
- xxvii** Health services should provide training for members of the multi-disciplinary team to deliver effective treatments for people whose symptoms worsen. Clinical governance teams should ensure that there is access to training, on the needs and care of people with joint pain and osteoarthritis, for all professionals involved in their care and support.
- xxviii** Health service planners and providers should actively engage local service users in reviewing and, if necessary, reconfiguring local service provision.^[38]
- xxix** People should have access to services to support them in returning to work or education. These could include post-operative physical rehabilitation, vocational rehabilitation and/or occupational health services, disability employment advisors and employment medical advisory services, who are able to work in liaison with employers and individuals.

Good Practice Example - C

A primary care and hospital trust has established a multi-disciplinary musculoskeletal biomechanical assessment clinic, to improve the patient's experience of services and relieve pressure on orthopaedic services. Referrals to orthopaedics are now triaged in podiatry or physiotherapy, with clear referral protocols so that those most appropriate for surgery can be referred on to orthopaedics; while those considered more appropriate for multidisciplinary care are managed in the foot clinic. This has resulted in earlier intervention for the patient, with rapid direct access to orthopaedics and/or orthotics where needed. It has also led to cost savings across the departments, and to more effective use of consultant time.



 For further information and resources, including details of ARMA's member organisations and other examples of good practice and information on implementation, visit www.arma.net.uk

32 Creamer P et al (2000); Penninx BW et al (2002); Department of Health (2004)

33 Keefe FJ et al (1987); Barlow J et al (2002); Barlow J and Lorig K (2003)

34 Lorig K and Holman HR (1993); Lorig K and Holman HR (2003)

35 Barlow J et al (2002)

36 Jordan KM et al (2003); Arroll B and Goodyear-Smith F (2004)

37 Ernst E (2000)

38 Fisher B et al (1999); Buckley J and Hutson T (2004)

Allied Health Practitioner (AHP)

a member of the care team who is not a medical doctor. For example a nurse, physiotherapist, occupational therapist, podiatrist, dietician, pharmacist.

Nurses are registered with the Nursing & Midwifery Council.

Health professionals are registered with the HPC (Health Professions Council) who regulate arts therapists, orthoptists, biomedical scientists, prosthetists, orthotists, chiropodists/podiatrists, paramedics, clinical scientists, physiotherapists, dietitians, radiographers, occupational therapists, speech and language therapists.

Pharmacists are registered and regulated by the Royal Pharmaceutical Society

biomechanical

relating to the mechanical function of the body or parts of the body

care pathway

see pathway

care plan

a written statement about a person's health needs; the treatment, support and advice they should have; who should provide these and when

community-based services

see primary care

interventions

a general term covering treatments, advice, education, and other care that a practitioner may give

multi-disciplinary team

a healthcare team that includes professionals from different disciplines, working together to provide a comprehensive service for people with joint pain and osteoarthritis

orthoses [orthotics]

devices intended to alter or stabilise the mechanical function of a joint or limb. This includes a range of splints, insoles and braces

pathway

a person's route or journey through care, which can include a range of different treatments and services

pain management programmes

combinations of treatments, advice and education designed to enable people to manage and cope with pain. They may include, for example, cognitive behavioural therapy, relaxation training, pacing of activities, use of Transcutaneous Electrical Nerve Stimulation (TENS)

pharmacological

drug-based treatments

primary care

care services available in the community, for example through a community pharmacist or the care provided by a GP. This is often a person's first point of contact for advice, information and treatment

red flags

a group of signs or symptoms (clinical indicators) that suggest there is a possibility of serious disease (pathology)

secondary care

care available usually in a hospital setting. People generally need referral from a professional in primary care

Appendix: Developing the Standards

The working group met five times between September 2003 and June 2004, and consulted widely and publicly on these Standards during May and June 2004.

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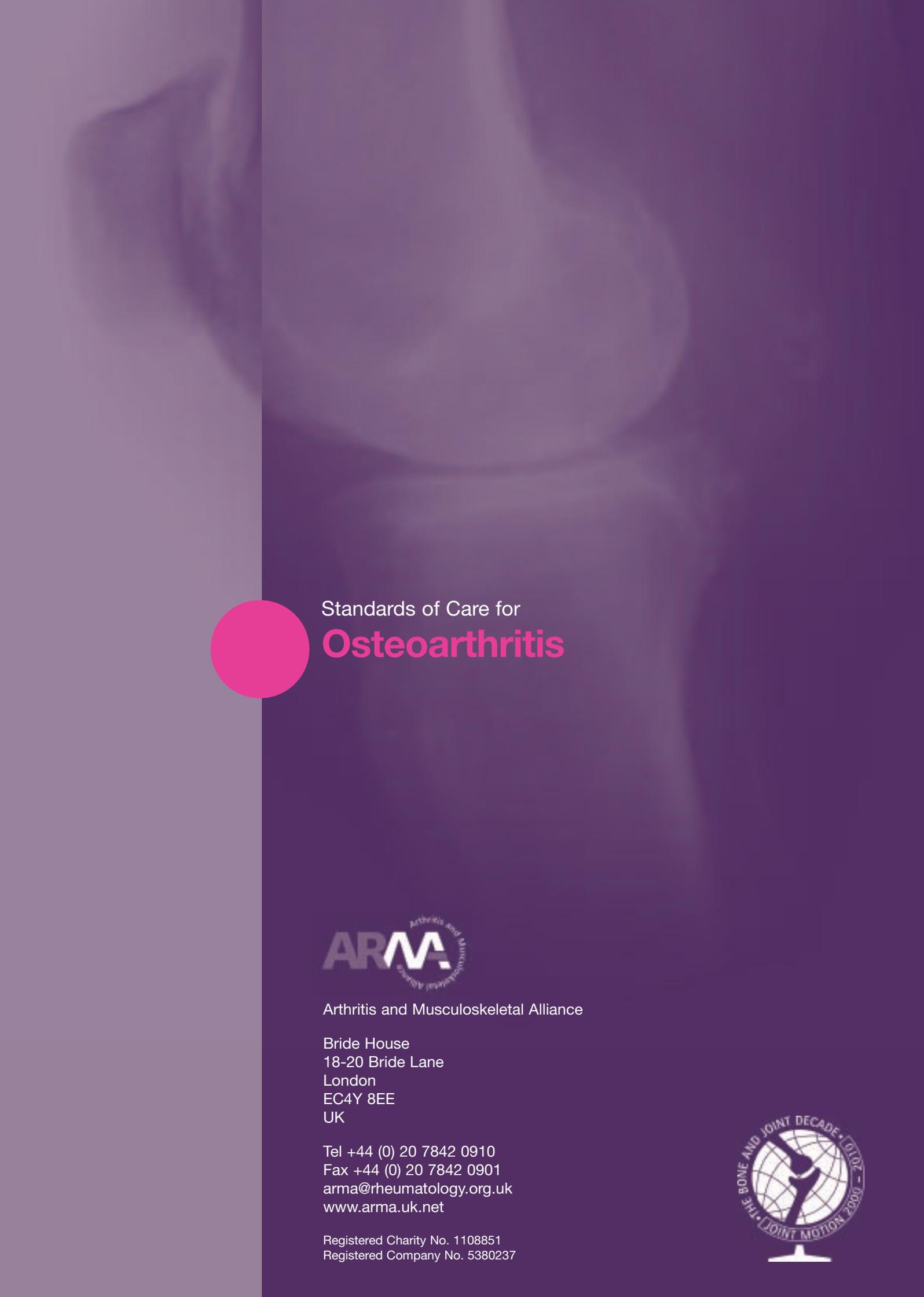
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