Good Governance Institute

Board assurance prompt:
improving the effectiveness of musculoskeletal health for NHS providers

Musculoskeletal (MSK) conditions now affect 1 in 4 of the adult population. They are the biggest cause of the growing burden of disability in the UK, and cost the NHS £5 billion each year.

What is this guide and who is it for?

Demand for MSK services is rising exponentially as the UK's population ages and grows. With capacity and resource already stretched across the NHS, this will have significant finance and performance implications for NHS providers, especially if local pathways are not configured optimally.

Recent reports, including the Carter Review, and pioneering initiatives, such as Getting it Right First Time (GIRFT) and the Model Hospital, demonstrate that there is an opportunity for NHS providers to get ahead of the curve and drive down costs through the design and development of best practice MSK pathways. This should be done in tandem with a range of stakeholders including NHS Trusts, commissioners, the third sector, and patients and their families.

This briefing is for NHS providers. It is intended to support such organisations plan and manage appropriate and effective orthopaedics, diagnostics, rheumatology, pain and MSK to their local population. In particular, it aims to help colleagues with no clinical background understand key healthcare issues relating to MSK. We have produced separate guidance on MSK health for NHS commissioners.

What are MSK conditions?

The term 'musculoskeletal conditions' encompasses a broad range of ailments which affect the body's tendons, muscles, nerves and supporting structures. These include everything from a minor self-limiting injury to a joint replacement.

Only a minority of MSK conditions ultimately require hospital services, however, often due to inefficiencies within local pre-hospital pathways, non-surgical patients are referred into secondary care when they can often be treated effectively within community settings.

MSK is a significant and growing problem

It has been estimated that there are 17.8 million people in the UK living with an MSK condition.[1] That is more than one in every four people.

MSK conditions can be progressive, meaning the impact can be profound though the importance is often underestimated since most are not immediately life-threatening. MSK problems can have an enormous impact on quality of life and are the single biggest cause of the growing burden of disability in the UK.

Those living with MSK conditions typically experience pain most days. Consequently, **MSK conditions are estimated to account for about 30 million lost working days each year, costing the wider economy billions.**[2]

MSK conditions are closely linked with old age, deprivation and multimorbidity: almost five out of every 10 people with heart, lung, or mental health problems also have an MSK condition; whilst, in the most deprived areas of the UK, the onset of MSK conditions occurs 10-15 years earlier than in the least deprived.[3]

MSK conditions comprise around 14% of all primary care consultations and 10% of all GP referrals to hospitals, resulting in approximately 1.36 million admissions to secondary care and 2.27 million bed days in England in 2016-17.[4]

The NHS in England currently spends £5 billion each year on MSK conditions.[5] MSK conditions also often bring forward the need for long-term social and residential care.

The prevalence of MSK conditions will increase exponentially as the population grows and becomes more aged, exacerbating the impact of the issues discussed above.

Much of this is avoidable. Early quality management of these conditions will keep people at work or enable them to return to work earlier, and reduce advanced treatment needs in hospitals in future years. This is often not happening at the moment adding to the burden.

Issues with the prevention and treatment of MSK conditions

Despite the significant access and financial challenges associated with hospital-based services, community MSK services which could make a significant difference, have historically suffered from underinvestment and a lack of awareness of benefits amongst both primary and secondary care clinicians and the general public.

Challenges to the treatment and prevention of MSK conditions include increasing demand, funding constraints, variation in the quality of care, and a disjointed and multi-provider landscape with perverse incentives. These contribute to excess referral of patients to secondary care resulting in a financial burden to acute trusts where contracts change from payment by activity to block.

1. Arthritis Research UK, State of musculoskeletal health 2018
2. Arthritis Research UK, State of musculoskeletal health 2017
3. Arthritis Research UK, State of musculoskeletal health 2018
4. Arthritis Research UK, What is the impact?
5. NHS England, Musculoskeletal conditions

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Recognising the dysfunctional nature of services, in 2006, the Department of Health published the seminal Musculoskeletal Services Framework (MSF) which sought to address some of these core issues. This document highlighted the importance of:

- Supporting self-care and care closer to home to ensure individuals fulfil their optimum health potential and remain independent
- Ensuring care was holistic in approach addressing psychological and social need, as well as physical
- Implementing multi-disciplinary interface services, acting as a one-stop shop for assessment, diagnosis, treatment or referral to other specialists.[6]

Subsequent NHS guidance, including the Next Steps on the Five Year Forward View, has built on this, stressing the need to reduce avoidable demand and meet demand more appropriately with MSK triage given as an example of where this could be realised effectively.

The publication of the NHS Long Term Plan saw renewed emphasis on "the importance of therapies and planned surgical services for conditions that limit independence and affect quality of life."[7] The Plan stresses the need for patients to have direct access to MSK First Contact Practitioners (FCP) and physiotherapists within primary care, and notes that 98% of STPs have confirmed pilot sites for FCP. When a patient does need an operation, the Plan highlights the importance of patient choice and shorter waiting times, and recognises that capacity for surgery has not increased rapidly enough.

At an individual level, there are a number of interventions which can support and improve MSK health. This includes regular physical activity, optimum weight and ensuring appropriate working and living environments. Educating the public on the importance of prevention approaches, as well as supporting them to self-manage existing conditions has a central role to support these interventions.

Other important tools and programmes which are supporting NHS organisations provide more effective treatment and prevention of MSK conditions, include NHS Right Care and GIRFT. These national programmes address unwarranted variation within the system, share best practice, and deliver meaningful savings, and are already demonstrating variation within secondary care with regards to clinical approach and cost to the NHS.

What are the key benefits of improving MSK prevention and treatment?

1. Reducing referral and treatments in inappropriate settings of care
2. Reducing the financial burden on the NHS and social care
3. Preventing those at risk of developing an MSK condition from doing so, and those who already have an MSK condition from deteriorating
4. Reducing workforce and performance pressure on the NHS
5. Improving patient experience and satisfaction

The rest of this guide

Overleaf are a series of assurance questions that board members and others developing services might ask to ensure that the local service development is progressing along sustainable lines to meet the needs of patients in the future and is focussed on better population outcomes. These assurance questions are examples only. We also provide our view about what an adequate and thoughtful answer to these questions would look like, and also what an unsatisfactory response would be. Often the adequate answer indicates something has happened or will happen, that it will be possible to monitor its implementation and effectiveness, and that there is accountability. The inadequate answer often suggests either lack of pathway development or ongoing activities in community pathways that are not monitored/evaluated and may be providing poor value for money.

6. Department of Health, Musculoskeletal Services Framework
7. NHS England, The NHS Long Term Plan

	Example assurance question	Good answer	Weaker answer
1	**Do we understand the scale and breadth of MSK conditions locally and the impact that this will have on demand?**	Working closely with other local stakeholders, we have thoroughly investigated the scale of the MSK challenge. This is reflected in published literature including the Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy, and other local plans. These demonstrate that the prevalence of MSK conditions is likely to increase as the UK's population grows and ages, and that focus is needed not just on service provision but also to address the wider determinants of poor MSK health. This includes through prevention and education initiatives. At our Trust, the quality of our activity and outcomes data is allowing us to monitor trends, forecast demand and plan appropriately.	We look at local access data and this informs short-term priorities and service design. The poor availability of meaningful data does not allow us to assess performance and understand how our MSK pathways should look.
2	**How are we assured of the quality of our MSK service?**	Our services are designed to focus on the patient experience and what really makes a difference to them: delivering care closer to home. Therefore, alongside key activity and outcomes data such as RTT, EQ5D and surgical conversion rates, we are also conducting local MSK-HQ surveys to ensure we have a holistic understanding of how patients experience our service. We benchmark our performance locally and nationally. This is helping to identify variation and promote good practice.	We monitor referral and admissions data internally.
3	**How have we optimally organised our MSK pathway?**	We know that effective partnerships are crucial to the design of efficient MSK services. We have therefore reconfigured our orthopaedic service to acknowledge this. This has included the engagement of a specialist community partner to improve the early pathway and ensure that appropriate triage into secondary care and financial efficiencies. Our KPIs, such as EQ5D score, RTT and surgical conversion rates, evidence improvement.	We have not reviewed the pathway since the change in contracting approach.

	Example assurance question	Good answer	Weaker answer
4	**How are we ensuring equitable and appropriate access to services?**	We recognise that variation in access as well as the quality of primary care and community care is problematic for the delivery of effective MSK services. We have therefore worked hard with local providers and other stakeholders, including the third sector, to ensure that patients are well-informed and that MSK services are clearly signposted and available. This might include advertisement, increasing use of technology, and the introduction of care navigators. This is helping to drive down outpatient waiting times and improving patient experience and outcomes. Patient experience is being evaluated through the use of local surveys and we are demonstrably acting upon the feedback we receive. This is supported by local analysis of clinical performance to promote standardisation and reduce variation.	This is an ambition of ours which we are working towards. However, there are issues with regards to accountability and communication which we have not ironed out yet.
5	**Are we prioritising prevention as well as treatment?**	We understand that an emphasis on prevention can reduce demand in primary care and inappropriate referrals to secondary care. Recognising that healthy lifestyles - diet, exercise and working environment - are central to the prevention of many MSK conditions, we work with local stakeholders including the third sector to communicate and raise awareness about MSK. This includes through Trust events and newsletters, and targeted and tailored local education programmes. We evaluate these activities to ensure their effectiveness. We are also increasingly utilising digital technology to support patients better manage their MSK conditions outside of hospital, including the use of virtual follow-up appointments.	Information on the importance of early interventions for MSK conditions is available on our website and on-site.

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BOARD ASSURANCE PROMPT MATURITY MATRIX

A tool to support improvement of the effectiveness of musculoskeletal (MSK) health for NHS providers

TO USE THE MATRIX: IDENTIFY WITH A CIRCLE THE LEVEL YOU BELIEVE YOUR ORGANISATION HAS REACHED AND THEN DRAW AN ARROW TO THE RIGHT TO THE LEVEL YOU INTEND TO REACH IN THE NEXT 12 MONTHS. 0 - 5

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PROGRESS LEVELS / KEY ELEMENTS	0 No	1 BASIC LEVEL Principle accepted and commitment to action	2 EARLY PROGRESS Early progress in development	3 RESULTS Initial achievements evident	4 MATURITY Results systematically achieved over time	5 EXEMPLAR Others learning from our consistent achievements
EFFICIENCY OF ELECTIVE ORTHOPAEDIC CLINICS	No	We have no visibility of those patients that don't require surgery. A significant proportion of orthopaedic surgery is outsourced to the independent sector resulting in loss of surgical income. Our surgical conversion rate from elective orthopaedics is less than 30%	We recognise that the conversion rate is a problem but haven't been able to solve it yet.	We have introduced evidence-based improvements to our MSK pathway, including from programmes such as GIRFT and Right Care. Our surgical conversion rate from elective orthopaedics is less than 50%.	Local analysis of clinical performance is periodically undertaken to promote standardisation and reduce variation. Our surgical conversion rate from elective orthopaedics is less than 70%.	Our outpatient clinics are attended primarily by those who need surgery. Our surgical conversion rate from elective orthopaedics is around 80%. We are auditing the <20% that are unconverted to ensure their appropriateness to enter the Trust pathway. All surgery is done by the hospital on block or tariff.
COMMUNITY MSK SERVICE	No	We don't have a community MSK service. We have no understanding of the supply chain, and costs are excessive on block contract	Our community MSK service historically lacks investment. We are taking direct referrals from GPs, many of which do not require surgery.	Our community MSK service is ineffective in protecting us from non-surgical capacity.	We understand the community MSK service and its benefits. We have high conversion rates and good visibility of the whole pathway. We can influence the appropriateness of referrals.	We utilise self-referral processes, provide community-based services, and a range of patient access routes are available. We have a lower use of diagnostics and lower onward referral rates. Our waiting times are less than 4 weeks.
DEMAND - ACTIVITY AND FORWARD TRENDS IN ELECTIVE ORTHOPAEDICS	No	We recognise that demand for elective orthopaedics is rising significantly year on year.	We are aware of the trend in activity levels for elective orthopaedics and have ran a GIRFT review. As a consequence, we have put plans in place to manage this.	Our demand curve has stabilised.	We have data on referral demand on orthopaedic surgery for the next 5 years. We have made predictions on increased demand and made provision to retain efficiency in conversion rate.	We benchmark our performance nationally using GIRFT. Over the last two years we have seen a flattening or decrease in demand. We have an effective community MSK service in place.
FINANCE - RE-EVALUATION OF BLOCK CONTRACT STRATEGY	No	We recognise that our pathways are ineffective and that this is causing us to outsource surgery and incur financial penalties.	We have reviewed and revised our community orthopaedic pathway. This process is reflecting on national guidelines and local needs, and involves local stakeholders.	Improvements in our MSK pathway, including more appropriate triage, is encouraging increased self-management of MSK conditions.	We have engaged a specialist community partner to improve the early pathway. This is further supporting us to avoid unprofitable work and financial penalties.	We have repatriated the surgical activity that previously we were outsourcing, and the Trust now carries out 100% of the surgical demand. We are avoiding unprofitable work and avoiding financial penalties.
RTT / ACCESS	No	We are typically unable to meet our RTT and waiting time targets. Local MSK pathways are currently fragmented across a range of organisations and services.	We are able to meet our RTT and waiting time targets most of the time but only by utilising the support of other providers. We have introduced a CATS service which is helping to ensure that patients are seen in the right place at the right time. We signpost and educate patients as relevant to ensure services are accessed more appropriate.	We have had a Right Care assessment and are acting upon the recommendations of this. Patients are uniformly involved in their own care, and appropriate patient self-referral is reducing activity in primary care. We are building links with the voluntary sector to improve access and services.	We meet our RTT target in orthopaedics the majority of the time. Waiting times for an outpatient appointment are typically 4-6 weeks. Patients feedback demonstrates sustained improvement to the quality of our service.	We meet our RTT target in orthopaedics 100% of the time. We are the provider of choice locally. Waiting times for an outpatient appointment are consistently under four weeks. The majority of our clinical activity is of high value. Self-referral patient access has led to a decline in activity in primary care. We have full information in terms of waiting times.

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