College of
Occupational Therapists

COT / BAOT Briefings

Musculoskeletal Services Framework 2006

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Introduction

The *Musculoskeletal Services Framework. A joint responsibility: doing it differently* (MSF) (Department of Health 2006) is part of the Government's strategy for long term conditions, along with *Supporting people with long term conditions: Improving care, improving lives* (2005) *and* the *National service framework for long-term conditions* (2005). It summarises the current state of musculoskeletal services in England, saying that while excellent care is happening in some places, in many areas services are fragmented, with poor access to care. As well as recognising the current inequalities in care, it also highlights the impact of lifestyle factors and preventable injuries. It describes how services could be improved and gives examples of best practice, built around evidence and experience. It recommends actions for changing practice, with the aim of supporting the improvement of services for people of all ages with musculoskeletal conditions, whether the result of disease, injury or developmental disorders.

There are over two hundred musculoskeletal conditions affecting millions of people of all ages, including all forms of arthritis, back pain and osteoporosis. With an ageing population, the incidence of these conditions will grow. The MSF's vision is for people to access the appropriate level of high quality, effective and timely advice, assessment, diagnosis, support and treatment, to enable them to fulfil their optimum potential and remain independent. Support and treatment are to be offered as close to home as possible and should be holistic in approach, addressing psychological and social needs, as well as physiological.

The MSF proposes that the improved services are systematically planned, based on shared care structured around the patient journey or care pathway, with integrated multidisciplinary working across health and social care economies.

The care pathway and shared care

Integrated care pathways (ICPs) form the basis of the improved services proposed by the MSF, based upon the entire patient journey, with the emphasis on prevention and self-care, with the patient an active agent rather than a passive recipient and on services that are seamlessly co-ordinated. The document provides a number of benefits of developing and implementing care pathways. An example of a pathway for adult patients with hip and knee pain is given to illustrate the principles of the MSF. (Department of Health 2006, page 8). More general information on care pathways is provided in *COT/BAOT Briefing 1 Integrated care pathways* (2005).

The MSF takes a shared care approach, structured around the patient journey. It gives a number of principles for shared care and suggests that success depends upon the commitment of well-informed healthcare professionals, the use of specifically designed information systems and

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systematic processes of care such as clinical protocols, referral guidelines and ICPs; ensured through regular audit and evaluation of services delivered.

Care outside the hospital

The MSF suggests that many people with musculoskeletal problems do not need to be treated in hospital and could receive faster and more appropriate care in a community setting, releasing hospital care to those who need specialist treatment. Health economies need to develop systems that reduce referrals to hospital, while ensuring that patients are directed towards the most appropriate services and clinicians.

The care proposed by the MSF is based upon the model described by the Department of Health in the in the NHS and social care model to support local innovation and integration in the management of long term conditions. (DH 2005) This uses case management, disease management, supported self-care and health promotion. Supported well-being and care is part of the underpinning health promotion message of the MSF and the LTC care model. Commissioners in primary and secondary care are encouraged to consider incorporating the improvements in well-being in line with key outcomes set out in *Independence well being and choice* and *Every child matters.*

- Information and advice

Information is a key part of enabling health promotion, self-care and condition management. Patients may need support to access and understand relevant information. It needs to be accurate, relevant, consistent and easy to read, with consideration given to the needs of people for whom English is not their first language, people who have impaired sight, who have a learning disability, and the needs of children and young people. Services are encouraged to make use of existing information and to direct people to specialist organisations, voluntary and community support, although health professionals will need to ensure that the advice given from such organisations is accurate and evidence-based.

In December 2004 the DH published *Better information, better choices, better health*, which envisions high quality information being easily available in a variety of ways, for example through interactive TV.

The Expert Patient Programme was established in 2002. It is a training programme for patients to develop new skills to manage their condition better, through courses delivered by people who have a long-term condition themselves. There is a planned expansion of the scope and staffing of the EPP to benefit supported self-care.

- New roles and new locations

With the development of more services in the community and the opportunity for practitioners to extend their roles, there is now greater opportunities for practitioners to work in new settings and in broader ways, with a sharing of skills and a cross-over of roles. An increasing proportion of contacts with health and social care is in primary care in walk in centres, which can support improved musculoskeletal services in the NHS.

- Lifestyle choices

This NSF looks at a number of lifestyle factors that can influence health and well-being, including physical activity and diet, smoking and excessive alcohol consumption.

The NSF cites a report from the Chief Medical Officer, *At least five times a week: Evidence on the impact of activity and its relationship to health*. This gives the research evidence to show the

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benefit of physical activity in the prevention and treatment of several conditions including musculoskeletal disorders.

With diet, the NSF refers to *Choosing a better diet: A food and health action plan*. This is aimed at people and organisations with an interest in improving food and nutrition. It focuses on obesity education and prevention and improved nutritional standards in school, hospitals and the workplace. Primary Care Trusts and health professionals are encouraged to follow the report recommendations.

The NSF also looks at the link between accidents, injuries and alcohol consumption. It recommends educational initiatives, the use of alcohol only in moderation and intervention to ensure safe homes and falls prevention.

The NSF also looks at health in the workplace, recognising musculoskeletal conditions caused or made worse by a person's job. It highlights the importance of accident prevention, occupational health advice, healthy workplace initiatives and the provision of good occupational health advice in the wider community, for example through back pain advice.
Medics and practitioners are encouraged to link with the Department of Work and Pensions – pathways to work pilots if set up in their local area.

- Rehabilitation Services, equipment and adaptations

Government policy is that rehabilitation services should be provided for all those that need them. The *NSF for Long Term Conditions* makes a series of recommendations to enhance specialist, community and vocational rehabilitation.

Equipment and telecare are a vital part of the support that enables people to maintain their independence in the community. Since 2003 all community equipment given or loaned is free of charge to those people who fit within certain criteria, as are adaptations under £1000. More information is available in *COT/BAOT Briefing 10; Changes to local authority charging regime for community equipment and intermediate care services LAC(2003)14* and *COT/BAOT Briefing 16: Fair access to care services LAC(2002)13*. In addition the DH has provided £80 million over 2006/08 in the form of Preventative Technology Grant monies, to fund the provision and installation of telecare and other preventative technology. Please see BOAT/COT Briefings 83 and 84 for further information.

Care at the interface

- Clinical assessment and treatment services (CATS)

These services are core to the framework. They bring together skilled professionals from primary and secondary care, including Allied Health Professionals (AHPs). The function of the team is to provide comprehensive assessment, diagnostic and treatment services for patients, along with training across professionals and organisational boundaries. The teams are located at the boundary between the acute and community settings, hosted by either or both.

The Audit Commission is cited as supporting the development of CATS. The precise structure and functions of existing CATS vary from place to place, but the generic functions are to :

- provide an expert multidisciplinary opinion for service users referred by their GP;
- screen for important remedial conditions and refer service users as appropriate;
- direct service users for appropriate services for investigations or referral back to the GP;
- conduct clinical assessment, organise diagnostic investigations, provide advice and treatment, including injections, inform and educate service users;

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- agree and test ICPs, which must be built on evidence-based guidelines, with locally agreed protocols and quality measures;
- facilitate referral, where necessary, to other primary or secondary care services with agreed referral processes in place that are understood by all;
- support the development of robust systems for monitoring and clinical audit; and to
- deal effectively with clinical conditions or symptoms, such as pain, back pain, trauma from falls, osteoarthritis, rheumatoid arthritis, osteoporosis.

Referral to CATS may be inappropriate for some such as children and young people, as their needs may require more specialised knowledge.

The MSF recommends that each health economy explore the CATS option and it is expected that most will choose to establish teams with the involvement of patients, and health and social care staff from all sectors. A number of practice points are given to consider and a series of tasks, including:

- assessing the needs of the local population;
- agreeing performance criteria and evaluation;
- building the team; and
- improving access to diagnostic services and creating links to social services.

Localities are encouraged to consider incorporating and integrating other services into CATS, such as falls and osteoporosis services.

CATS that have been successfully developed have had close collaboration between clinicians and robust governance, strong leadership and clear accountability. Case studies of successful CATS have shown that they do improve local services.

Hospital Care

The MSF looks at the rheumatology and pain management services provided in hospitals and quantifies some of the financial and social costs of such conditions, including condition-related days off work. It concludes that early diagnosis could be very cost-effective, especially if it resulted in people being able to remain at work for as long as possible.

The MSF states that hospital outpatient rheumatology services should focus at the first referral on the assessment, diagnosis, treatment and continuing care of service users with complex auto-immune rheumatic diseases. The same services should also be provided for those with other major inflammatory diseases. Outpatient service should cater for metabolic bone diseases, osteoporosis and the provision of advice on more complex diagnostic or management issues of minor inflammatory conditions. These services should be provided at secondary care level, but with close collaboration with primary care professionals for optimal day-to-day management.

The MSF suggests that monitoring clinics run by AHPs and specialist nurses/practitioners are used to review those with inflammatory arthritis, providing education and support to enhance self-management. These may be held in community settings. Advice may be provided by telephone services and/or disease specific patient education programmes.

The MSF goes on to describe when rheumatology patients may require admission, for example for assessment and intensive management of newly diagnosed arthritis or exacerbations, for the use of intensive or new medicines or when there are complex cases requiring the input of a range of treatments. Where home services are available, some of the services may be carried out at home.

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- Specialist commissioning

While arrangements will vary across the country, the MSF states that a core rheumatology service should be provided in all local hospitals, with specialised services being located in fewer centres with local hospitals referring patients in to the centre. All rheumatology services should be part of clinical networks.

- Pain Management

The MSF recognises that pain management services are multiprofessional and can include occupational therapists. Pain management services can provide information, use psychological techniques and practical strategies to manage pain, enabling service users to remain active despite pain, so improving their physical function and quality of life. Some service users have combined problems of severe pain and moderate to severe mental health problems as a result of the pain. Such people require a combined medical and psychological approach.

Most pain management services will be based in primary care and CATS. In some critical conditions hospital intervention and care may be required. The hospital-based component of pain management needs to be planned and commissioned as part of an overall pain management pathway. There needs to be improved access to appropriate pain management services with clear care pathways in and out of services.

- Rheumatology and pain services for children

The MSF states that musculoskeletal conditions are the biggest cause of disability in children, with serious educational, social and physical effects. For this reason multidisciplinary teams are to develop expertise in assessing the needs of children as well as adults, with clear care pathways for caring for children and adolescents and for managing the transfer into adult services. The MSF provides further information concerning the needs of children and their families.

- Surgical intervention

Surgery can restore normal or near normal function in many musculoskeletal conditions. In more standard conditions eg hip replacements, it is very cost effective. In more complex situations the goals of surgery may be limited as a treatment option, but still worthwhile.

The MSF gives statistics for the top 25 health resource groupings for 2003/2004. These account for 75% of the workload for trauma and orthopaedics. The figures show that limb fractures and accidental injuries form the largest group of first consultant episodes, including fractured neck of femurs, complex elderly cases, hand injuries and joint replacements. Of elective surgery joint replacements and carpal tunnel releases form the largest groups.

For children between 1 and 14 years old, a high proportion of surgery relates to trauma, caused by accidents and sports injuries. There are more admissions in the 10-19 age group than the under 10s. Commissioners need to consider the particular needs of adolescents using hospital-based musculoskeletal services.

Pain control for children in both emergency and elective settings is often underestimated. Audited protocols for assessment and management of acute pain need to be in place in every children's unit. Following the publication of the Department of Health consultation document, *The critically sick or injured child in the District General Hospital: A team response* a consultation document to review children's services, it was widely agreed that the more straightforward children's orthopaedic services should be delivered in local district general hospitals, and more complex work concentrated in specialist centres.

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- Trauma

The treatment of traumatic injuries is approximately 40% of the work of trauma and orthopaedic services. The MSF notes that older people are especially at risk and it recognises this as an increasing trend. It suggests that a shift in care is required to prevent this trend from overwhelming surgical musculoskeletal services, and further investment is required in trauma services.

The MSF promotes the expert early management of trauma patients, reducing the level of later disability and the understanding of the complexity of rehab requirements of older people, often with co-morbidities. Primary Care Trusts (PCTs) need to assess the future requirements for orthopaedic care of the elderly, including occupational therapy and physiotherapy specialising in care of the elderly fracture patients, so as to reduce the potential stay in hospital and to gain better outcomes.

The occurrence of one fragility fracture is seen as a strong predictor of having another. Thus elderly fracture patients need advice, investigation and treatment, all aimed at preventing further fractures. Fracture prevention is seen as a key part of this management, with falls prevention and osteoporosis treatment services. Services need to adopt evidence-based guidelines in the prevention and management of hip fractures in older people.

Some commissioning guidance is given with the aim of ensuring balanced provision of services across all health economies, timely trauma and elective services and adequate planning for the future. Localities for general and specialist services need to be considered along with waiting times and levels of activity.

- Discharge and follow up

In order to maintain the quality of care as hospital stays are becoming shorter, it is important that everyone involved in the discharge process agree protocols that support timely discharge. Such protocols should be underpinned by excellent communication and should include information to patients and their carers on the expected length of stay; the treatment plan and discharge process; the full assessment of social and support needs of patients and carers in line with the principles of the Single Assessment Process and Common Assessment Framework and the provision of information, equipment and orthoses to maximise independence.

Following discharge continued rehabilitation should be ensured when needed, along with effective follow-up arrangements that identify and deal with complications. Discharge planning should include follow-up arrangements, information about signs and symptoms to look out for following discharge and what to expect at each stage of the recovery process. Information about entitlements to benefits and eligibility for social care services is important for those individuals who are likely to need ongoing support

Supportive, palliative and end of life care.

Certain patients with long term conditions may need specialist palliative care. The NICE guidelines on supportive and palliative care for adults with cancer are the benchmarks for such services. While written for cancer care, many of the principles apply to people with certain musculoskeletal conditions. The DH has produced commissioning children's and young people's palliative care services 2006 that sets out good practice points.

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Making the changes

The Government reform agenda is driven by a set of policies that are designed to ensure that the NHS offers high-quality, efficient and patient-centred care. Central to these policies is the document *National standards local action: Health and social care standards and planning framework 2005/06 – 2007/08*. The national targets in this document are fewer than in previous years, but includes a specific focus on people with long-term conditions. Amongst these is the key target that no one will wait more that 18 weeks from GP referral to hospital treatment. Since April 2006 service users have had an extended choice of service providers. By 2008 service users will be able to choose any healthcare provider that meets the required standards.

The final chapter of the MSF briefly highlights the key changes that health economies will need to make in order to improve the care of people with musculoskeletal conditions, reducing waits and delays to deliver the 18-week patient pathway by December 2008. Commissioners will lead much of the change, but all key stakeholders must be included in the process across health and social care, including patients and their families.

The basic delivery cycle for the NHS is identified, consisting of:

- assessing population needs;
- identifying priorities and standards;
- planning services;
- commissioning services to meet assessed needs;
- managing performance and auditing, assessing and inspecting outcomes.

It is suggested that local health economies may wish to use this as the basis for implementing the recommendations contained in the MSF. The government expects commissioners to look at more strategic commissioning arrangements between healthcare, social care and wider care communities, to support a shift away from hospital care towards more effective prevention. This has particular significance for the support of older people, enabling them to maintain an active and healthy living and to avoid unnecessary or emergency hospital visits.

A key task for health economies is to specify and agree with all partners care pathways that move from prevention and self care through to hospital care, working across the interface between primary and secondary care. It is recommended that they all look at creating clinical assessment and treatment services at the interface between primary and secondary care.

A number of guidance documents published by the National Institute for Health and Clinical Excellence (NICE) are also relevant to musculoskeletal services. Assessing the implementation of NICE guidance is an element of national standards against which the Healthcare Commission checks an organisations' performance.

The National Library for Health hosts a specialist library for musculoskeletal disorders at:
www.library.nhs.uk/musculoskeletal/ (Accessed 18/06/2207)

The Department of Health web site will also have further guidance documents as they are developed. www.dh.gov.uk (Accessed 18/06/2007)

If you have examples of successful musculoskeletal care pathways that include occupational therapy, please inform the College using use the form at the back of this briefing.

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Musculoskeletal care pathways

The College is interested to know how much and in what ways occupational therapy has been incorporated into musculoskeletal care pathways. If you know of or are part of such a pathway, please fill in your details below and send or fax it back to us (Details below). Please indicate if we may share this information, including your contact details, to assist with occasional enquiries we may receive about service integration. Thank you.

Service Title				
Service Address				
Contact name & telephone number				
Are you happy for these details to be shared? (Tick as appropriate)	**Yes**		**No**	
Please describe your service and how it is incorporated into a musculoskeletal care pathway. Please attach a diagram if it is easier to explain.				
Please describe any benefits that you may have experienced.				
Please describe any difficulties you may have experienced.				

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