MSK networks resource pack
Appendices
1. Case studies

Case studies are provided as potentially useful illustrations of how some CCGs and service providers have gone about improving MSK services through developing formal or informal MSK networks. It will be up to each local CCG to work out what model of service delivery will work best in terms of improving patient outcomes, and embodying sustainable, incremental service improvements. As further areas across NHS England develop networks to design and deliver sustainable MSK service improvements, further examples will be added where possible. Developing MSK networks to design and deliver MSK service improvements is an area where learning is ongoing and continuing to develop.

1A. EALING CCG case study

What is the value of MSK networks?

An MSK network is vital in that it enables effective engagement with stakeholders, building relationships between commissioners and providers, whilst keeping patients at the centre of our focus. Innovation and creative thinking is encouraged - and networks can more easily survive organizational change and top-level reform: they endure.

Two other critical factors for effective change in MSK services are patient engagement - essential both for understanding the values that people have and the outcomes they want from integrated care - and workforce education, especially for GPs, community staff, and relevant hospital workers.

What was the impetus for this work and what did you achieve?

About 20 years ago, patients could wait for a year before being seen by a physiotherapist. GPs had to refer to a hospital consultant first, who would then refer on to physiotherapy; all MSK services were provided in secondary care. The first step change was when some GP practices decided (via fundholding) to buy in their own physiotherapy services.

The second step (post-fundholding) was when a community MSK service was set up for all of Ealing, using the same budget. Then in 2008, we introduced a ‘See and Treat’ model: this was basically a central booking service where a GP could refer patients to either physiotherapy, an interface service, or to hospital. However, we then noticed that there was a fourfold difference in referral rates between different GPs in nearby practices, which couldn’t be clinically accounted for by differences in the underlying populations. The large variation in referral rates identified areas for
quality improvement in making diagnoses, managing patients in primary care and selecting the most appropriate referral destination at the most appropriate time. We achieved this by a combination of workforce training and restructuring the clinics. An extensive GP education programme, which improved GPs’ confidence and skill in managing MSK conditions, was a key factor in reducing the variation in referral rates. Orthopaedic referrals are triaged but GPs can refer directly to the MSk interface service or to physiotherapy.

We have significantly reduced waiting times for patients, and we generally aim to achieve 90% of patients being seen by a physiotherapist or an MSK physician within four weeks of their first presentation to the GP, with urgent referrals being offered appointments within two weeks – a significant change from 20 years ago!

What did you do?
The very first step was to get MSK health needs written into the local Joint Strategic Needs Assessment (JSNA). This helped to raise awareness of MSK morbidity and lack of service provision, and secured the wider support of the CCG for the service changes.

The next thing we needed to do was to get stakeholder buy-in from commissioners, GPs and also the acute trusts who we hoped would facilitate consultants doing work in a community setting.

To do this, a core strategy group was established, comprising clinicians from the community MSK service, commissioners, GPs and secondary care representatives. Initially we mapped out what good care looks like. This helped to overcome the divisive internal market, so that we could achieve our aim of providing better care for patients. Members then had synchronised key messages for their different organisations, and ensured a coordinated approach as we worked towards our goal.

It was essential to engage GPs effectively and so we gave them the opportunity to contribute to the service redesign. We also made sure there was an extensive engagement programme using multiple channels of communication about the proposed service changes. We used clinical scenarios to showcase how the service redesign would improve care for patients and impact referrers. The education programme, which has now been running for over 5 years, has also been key to both gaining their support, and in improving patient outcomes through improving the quality of diagnoses and referrals.

What are you doing now?
We are now exploring how we can integrate MSK services for people with multiple morbidity, and also promote prevention of other conditions by addressing health
literacy and social determinants of disease by joint working with public health and local authority colleagues.

Central London, West London, Hammersmith and Fulham, Hounslow, and Ealing CCGs formed the CWHHE CCG Collaborative a three years ago. CWHEE has an MSK clinical network, comprising commissioners and providers across the five CCGs and nine providers, and also patient representatives. The network conducted a service review, resulting in a new service specification for community MSK services in North West London – very similar to what we already have in Ealing – to which all the CCGs and providers are committed. Ealing’s short term goals to reach the CWHHE service specification involves developing both a community pain service and a community rheumatology service, which will be of great benefit to patients.

Why was GP training so important to achieving success for improving patient outcomes?

MSK conditions are given little attention in UK medical undergraduate education, with the result that many GPs lack confidence or skills in diagnosing and managing these very prevalent conditions. Training in Ealing for GPs, practice nurses, health care assistants and managers, has included both lectures, small group sessions, and outreach by senior therapists to individual GP practices. Additionally, GPs and registrars can attend the interface clinics where one-to-one teaching is offered to meet their specific learning needs.

How was the service redesign and implementation funded?

We funded increased physiotherapy and interface service provision by saving around a quarter of a million pounds a year of recurrent funding by decommissioning GP access to MRI scanning. Access to MSK imaging is now through the interface service and this has resulted in both shorter waits for scanning and definitive treatments such as physiotherapy or surgery. The community services are provided on a block contract and, overall, the service redesign is currently breaking even.

What have been the benefits? To patients? To clinicians? To commissioners?

The great benefit to the patient of the ‘See and Treat’ interface service, once referred by their GP, is that treatment can be started with the practitioner they see first. The service comprises extended scope therapists and MSK physicians, who can all start exercise and manual therapy treatments. The MSK physicians are also trained osteopaths. Secondary care consultants attend clinics within the interface service, advising extended scope therapists and MSK physicians if a second opinion is required.
Direct GP referral to physiotherapy provides the backbone of the high volume MSK service. The service is piloting health care professional-guided self-referrals to improve patient access and engagement with physiotherapy as well as reducing non-attendance. Patients move seamlessly between physiotherapy, interface and consultant clinics, facilitating access to the appropriate treatment more quickly.

The ‘See and Treat’ interface service also means the patient gets appropriate treatment sooner, unlike a triage service. This also reduces unnecessary referrals to secondary care and reduces healthcare utilisation in the longer term by preventing patients fruitlessly bouncing between physiotherapy and secondary care.

Access to MSK MRI scans via the interface service has resulted in ensuring that scans are only performed where this would influence clinical management. The reduced volume of scanning since decommissioning GP access has resulted in much quicker access to scans for those patients who need them, and has also shortened the wait for a consultant opinion about surgery or other interventions.

The interface service also considers the mental health aspect of MSK conditions; around 25% of patients with chronic MSK pain also have major depressive symptoms. The interface service liaises with the local Increasing Access to Psychological Treatments (IAPT) service. Appropriately treating mental health problems improves the prognosis for MSK pain, which can be of great benefit to patients’ quality of life.

**Patient stories**

1. **Speedier access to relief from severe pain and earlier return to work**

   A 32 year old male bus driver was off work for four weeks with severe sciatica. Following GP referral, he was seen within two weeks – compared with seven weeks in the old service – meaning a five week saving in time for the patient, during which he would have had poorly controlled and severe pain. On his first visit, he received a clinically guided caudal epidural. His pain levels rapidly reduced and he was able to return to work four weeks later.

2. **Early diagnosis and treatment of Ankylosing Spondylitis (AS)**

   AS is notorious for being diagnosed late – some cases taking years to be accurately identified and treated. In this case, a 50 year old man, with a family history of seronegative arthropathy, saw his GP with a recent flare-up of severe pain and stiffness in his back. His GP referred him to an extended scope physiotherapist (ESP), whom he saw in three weeks rather than seven under the old service. Suspecting AS from the history and examination, the ESP requested an MRI of the whole spine and sacroiliac joints. This was performed a week later, and the patient was seen two weeks from the initial appointment, compared with five to six weeks under the old system. The diagnosis of AS was confirmed and the patient was referred urgently to
a rheumatologist for further management. Total time saved on the patient journey to starting definitive treatment: seven to eight weeks.

Key learning points: speedier access to the interface service and appropriate imaging, coupled with early access to specialist opinion, enabled this patient to have a timely diagnosis, earlier relief from pain and appropriate treatment than would have previously been the case

3. Early access to physiotherapy reducing risk of work-related absence

Under the old system in Ealing, waiting times for physiotherapy used to be around 18 weeks. In this case, a 27 year old tele-sales executive presented with work-related upper limb disorder. Her GP referred her to physiotherapy and she was seen in four weeks, a saving for the patient of fourteen weeks further waiting for treatment. This resulted in an earlier return to work facilitated by advice on workstation adjustments and changes to her pattern of working.

1B. Pennine MSK Partnership, Oldham CCG case study

_Pennine MSK Partnership is commissioned by Oldham CCG, to provide rheumatology, orthopaedics and chronic MSK pain services through a new organisational form, the Integrated Pathway Hub._

**What is the value of MSK networks?**

MSK networks should operate in a similar way to cardiac and stroke networks: that is, they should identify best practice and ensure that this is implemented. Within MSK, networks need to be clear about what the best practice pathways are, and be able to support places that are struggling. In other words, they need knowledge of the area and knowledge of implementation. Clinicians need to be incentivised to improve care, and service quality can be improved with a good framework. Networks also allow frontline clinicians to have a key role in service improvement, and be accountable - as opposed to being drones in acute sector. The organisational structure is key because in the acute sector the necessary focus on MSK isn’t there.

Whichever type of MSK clinician leads a core provider for integrated care, that organisation is either going to have to employ or develop close relationships with other types of MSK clinicians. There must be real trust and team-playing from other clinicians. This can’t be achieved overnight - and if this does not already exist, time and effort needs to be put into it in order to develop this. Because of the nature of MSK, and the multi-disciplinary nature of those working within it, MSK clinicians need to develop a shared vision of integrated working that crosses traditional care organisations, roles and boundaries.
What was the impetus for this work and what did you achieve?
We had a desire to focus on improving patients’ outcomes, rather than being micromanaged against detailed, process-driven key performance indicators. Care was fragmented, and there was a lack of effective performance management of care and outcomes. Payment by results also contained perverse incentives to deliver more care in acute settings.

In 2002 the MSK clinic was in secondary care; a GP also worked at the clinic, which at the time was seen as an innovative aspect of the service. In a large acute trust, MSK is always going to be a small fish, and elective orthopaedic surgery is a cash cow.

The PCT then funded a post to develop an interface service and this led to a 50% reduction in patients being referred on for a consultant’s opinion. Specialists ran the service, which was structured as a GP clinic. We developed a service level agreement with the PCT and orthopaedics was also brought into the clinic.

50% of elective surgery was shifted away from the acute provider. The PCT then decommissioned secondary care rheumatology, and the service developed further. By this time Pennine MSK was looking after 80% of patients.

What did you do?
A rheumatology nurse consultant and two GPs initially developed the service. Clinical leadership has been vital in helping to overcome the initial lack of interest among GPs and helping clinicians develop a shared vision. In 2002, the service began as a triage system for rheumatology referrals and diverted 50 per cent of GP referrals away from hospital. The service managed patients who didn’t need to see a consultant rheumatologist and ensured that those patients who were referred to secondary care were appropriately investigated before seeing a consultant.

In 2006, we were commissioned to provide an integrated community MSK service, which incorporated rheumatology, elective orthopaedic outpatients and chronic pain services. A Specialist PMS (Personal Medical Services) contract then incorporated our lead accountable provider responsibility in 2011.

The service had a common referral entry point for all MSK problems. The challenge was then to develop a Programme Budget, in order to get best value out of the commissioning spend. We did this by developing one single integrated budget for MSK services. We have used both programme budgeting and marginal analysis in order to develop a framework which helps commissioners make, track and evaluate their decisions around spending on healthcare.
What are you doing now?
We've set up data systems to identify unwarranted variation that suggests suboptimal use of resources. We then work with referrers to ensure evidence-based and best practice pathways are followed as much as possible by operating a referral gateway for all referrals in MSK.

The focus on commissioning in this contract is now on health gain: we use tools such as PROMs (patient reported outcomes measures), based on the framework we developed which combines programme budgeting and marginal analysis. This is an improved alternative to PbR (payment by results), which created perverse incentives against delivering best value high quality MSK care.

How was the service redesign and implementation funded?
The service was initially helped by funding from the then PCT. It’s helpful here that the CCG is co-terminous with the local authority. The CCG has merged programme budgets and this is good because it has aligned incentives, and it also helps us to identify unwarranted variation.

The budgeting system is based on health gain rather than activity and this helps ensure that we can get the best possible care for a population within a determined budget. We used a range of different data sources to plan the programme budget, including: Health Investment Packs; prescribing data; Health Episodes Statistics (HES) data; Health Inequality Data Packs; the Spend and Outcome Tool (SPOT); and the Inpatient Variation Expenditure Tool (IVET).

What have been the benefits? To patients? To clinicians? To commissioners?
True clinical leadership and financial accountability led to a high quality patient experience. Another key factor for optimal patient outcomes is our adherence to best practice pathways. Also for staff, this kind of clinic is fun to work in.

There is a demonstrably better quality of MSK services overall. The clinical team work across traditional care boundaries and gain experience of working in integrated teams. With primary and secondary care clinicians working together to lead a new organization, this is much more likely to ensure successful outcomes for patients.

We practice shared decision-making and also support self-care. This is good for patients, and also prevents unnecessary referral to secondary care. National survey data showed for many years that over 40 per cent of patients wanted more involvement in their care. Given this, and evidence that shared decision-making leads to improved outcomes and greater patient satisfaction, shared decision-
making has been central to our approach. We implemented the AQuA shared decision-making model over a period of two years.

Pennine MSK provides what commissioners want: there are good clinical outcomes, and it’s value for money. For example, MSK spend per head decreased by £10 in Oldham compared to an increase of £10 nationally (for the period 2009/10 to 2011/12). Also, Oldham’s knee replacement patients received an average health gain of 0.35 in 2011/12, compared to 0.27 in 2009/10, representing a statistically and clinically significant increase in patient health outcomes. (The England average health gain was 0.30 during the period.)

For commissioners, the outcome analysis helps to ensure the whole pathway follows best practice and promotes best value, because we now measure health gain rather than healthcare activity – we use various tools such as PROMs and quality of life measures to do this. The key benefit of the integrated budgeting programme is that better MSK healthcare is delivered for the same commissioning spend.

Hence, the service is part of solution and not part of the problem. We have a streamlined decision-making process compared with acute services. We run like a GP practice, with organisational simplicity, and we have a flat management structure. 50 people work here including a physiotherapy consultant and GPwSI (GP with a special interest in MSK), and other consultants. The clinicians here are genuinely interested in MSK and provide a high quality service to patients. Any concerns can be dealt with quickly and in a positive way, and this incentivises people – which would have been inconceivable before. We’ve also been through a rethinking process, which has included agreeing outcome measures for implementation and patient self-management – triangulation is important.

**What still needs to be done?**

We need to coordinate the integration of primary care around this and we are not sure how to achieve this yet. There are still high and low referring practices. We need to empower patients to improve both self-management and also to act as advocates. It would also be good to have better PREMs and PROMs.

In other CCGs, a need continues to move away from the perverse incentives of payment by results which reward discrete multiple episodes of care towards a system that rewards and hence will be more likely to deliver better value across a programme of MSK care for a defined population.

For further information, see [www.pmskp.org](http://www.pmskp.org)
Patient story
A 46 year old gentleman presented to the service in 2011 with severe rheumatoid arthritis, demonstrated by a high Disease Activity Score (DAS) of 5.92. Through shared decision making with specialist nurses he was treated to target with triple combination therapy but his disease activity remained high. After 6 months of treatment he was offered rapid access to biologic therapy according to NICE criteria. His arthritis is now in remission and with the support of a multi-disciplinary team he has returned to work and successfully stopped smoking after a brief intervention.

2. Getting started
2A. Initial Steps
A key initial step is developing a **business case** for change and using this to build the confidence of the CCG board, using patient stories to highlight where service changes will make a difference to patient outcomes.

It is also key to have proper and detailed **public-patient engagement exercise**; this also helps professional groups to be seen in context and start working across professional silos.

“Use the patient voice as the leader of and justification for change. This is not easy but it's the right way forward.” (Sheffield CCG)

Sustainable change is incremental, and is dependent on **building relationships** so that effective working partnerships are established. This can be a culture change for health professionals and success depends on building trust across conflicting silos, which all have huge work pressure.

It is important to **build flexibility into the system**; this is a key, common denominator. Existing structures, processes and attitudes cannot be changed if the system is a rigid one, and flexibility is essential in enabling “culture change” to become a reality.

**Perseverance** is another key factor – building networks, and implementing sustainable, effective change across complex MSK pathways is going to take time.

Gaining and using peer support and accessing resources from the national working groups on national MSK priorities can also help tackle particular challenges during the redesign and implementation of improved MSK services.
2B. ROADMAP FOR IMPLEMENTING A LOCAL MSK NETWORK

1. Identify and agree the need for a network. Initially this may be between the senior MSK commissioner from the CCG with a local lead clinician, such as GP with special interest in MSK.

2. Identify stakeholders (refer to 'The MSK 9') to establish who is needed on the network. It is important to ensure the pathways are represented fully, but remember you don't need to invite everyone to every meeting! Map out all MSK service providers in the network’s local area.

3. Create a clear vision statement which sets out the key priorities for the network. This should be shaped to reflect the network stakeholders and should involve patient and public engagement exercises to help develop the initial vision, and gain agreement for a way forward across the different MSK professional groups.

4. Establish a baseline and identify any gaps, ensuring that MSK is written into the JSNA. Use data from appropriate sources including internal clinical audit and local intelligence from both public health and patient experience.

5. Create an annualised workplan to illustrate key activities and actions to overcome and address gaps and local/ national priorities of the MSK service.

6. Produce timely reporting, monitoring and progress reports through an agreed communications management strategy, checkpoint report and highlight report.

3. MSK Knowledge Network and National Working Groups

The MSK Knowledge Network is coordinated by ARMA together with NHS England, and is a forum for peer-to-peer learning, information-sharing and improvement. It is open to all commissioners and clinicians with an interest in working collaboratively to deliver person-centred, coordinated care for all people with MSK conditions.

The National Working Groups in each of the collaboratively identified MSK priority areas aim in general to be a source national guidance for local implementation. They will assess and assemble resources which will be of use to local, and in due course regional, MSK networks to help implement sustainable and effective MSK service improvements, supported by the best available evidence and examples of good practice. For more information, and to join the MSK knowledge network, go to: http://arma.uk.net/msk-clinical-networks-project/arma-associated-ccg-networks/
4. Further resources

4a. Fracture Liaison Services

- In the UK, FLS have demonstrated significant cost savings over a 5-year period and up to nine times higher rates of assessment and treatment for the prevention of secondary fractures than other models of care found in the UK.\[5\]
- Each year in the UK fractures result in around 85,000 hospital admissions and cost hospitals approximately £1.9 billion.\[6\]
- In 2011, it was estimated that half of all hip fracture cases were secondary fractures and up to half of the subsequent cases – about 20,000 cases a year – could be prevented.\[1\]

The Department of Health’s ‘Falls and Fractures: effective interventions in health and social care’ paper outlines four objectives, in order of priority, that have been empirically shown to have a positive impact on the management and treatment of falls and fractures. An effective local FLS provides a systematic approach to achieving these objectives.\[7\]

In 2014 the FLS Implementation Group (FLS-IG) was convened by the National Osteoporosis Society to work in collaboration with health professionals, commissioners, charities and patients to improve access to and quality of FLS, and therefore prevent subsequent fractures through a multidisciplinary approach. It subsequently linked into the ARMA/NHS England Clinical Networks Project. The FLS-IG provides leadership and coordination across projects designed to increase FLS provision across the UK, striving to achieve a common coordinated strategy.

To enable delivery of this work programme, the National Osteoporosis Society, in conjunction with the FLS Implementation Group, has developed a range of resources and support, which are hosted on their website www.nos.org.uk/fls including:

- **UK FLS Standards**: [www.nos.org.uk/standards](http://www.nos.org.uk/standards)
  The FLS Clinical Standards provide the core standards that every FLS should meet to ensure that correct identification, investigation, information, intervention and integration with primary care are achieved, within a framework of quality, to the long-term benefit of fracture patients - the 5IQ approach

*Case studies and other exemplars are included in this document, will be of interest to commissioners and others wishing to develop and implement, or upgrade, a local FLS.*
By adopting these standards, evidence-based best practice can be replicated effectively across the UK to reduce the burden of fractures while improving outcomes for patients and ensuring appropriate use of NHS resources.

The standards have been endorsed by the following organisations: the British Geriatric Society, the British Menopause Society, the British Orthopaedic Association, the British Society for Rheumatology, the Chartered Society of Physiotherapy, the International Osteoporosis Foundation, the Royal College of GPs, the Royal College of Physicians, the Royal Pharmaceutical Society, and the Society for Endocrinology.

- **Fracture Prevention Practitioner (FPP) accredited online training programme:** [www.nos.org.uk/fls](http://www.nos.org.uk/fls)
  This training programme aims to enable FPPs to deliver excellent health care to people with or at risk of osteoporosis and fragility fractures throughout the UK, using nationally agreed best-practice standards. This is the only programme of its kind that provides the underpinning knowledge required to deliver best practice; competencies have been developed to provide assurance of this. The course has been developed by key experts in the field of osteoporosis and has been reviewed by a number of leading practitioners across the UK. In addition, it has been reviewed by clinical experts affiliated to the National Osteoporosis Society.

  The programme has been endorsed by: the British Geriatric Society, the British Orthopaedic Association, the Chartered Society of Physiotherapy, the International Osteoporosis Foundation, and the Society for Endocrinology, and is accredited by the Royal College of GPs, the Royal College of Nursing, and the Royal College of Physicians.

- **FLS Implementation Toolkit:** [www.nos.org.uk/toolkit](http://www.nos.org.uk/toolkit)
  The FLS Implementation Toolkit has been developed by the National Osteoporosis Society, with support from relevant professional bodies, and has been endorsed by the British Geriatric Society, the British Orthopaedic Association, the Chartered Society of Physiotherapy, the International Osteoporosis Foundation, the Society for Endocrinology, and is awaiting endorsement from NHS England.

  The Toolkit has been designed to support health professionals and commissioners to set up an FLS or develop existing services and to save the time and trouble of researching, drafting and editing the relevant documents required. It will help both providers and commissioners (CCGs) to understand the local impact of fragility fractures, both in terms of numbers and socioeconomic costs; predict the local increase in fragility fractures over the next 5-10 years because of the ageing population; and provides a local model of the clinical and cost effectiveness of developing an FLS through an evidence-based business case. This will help to ensure
that a high-quality, effective FLS is developed, and integrated within a system-wide approach to falls and fracture prevention across the UK.

The toolkit includes the following documents/resources:

- Call to action
- Service improvement guide
- Project planning tool
- Benefits Calculator
- Service specification
- Business case
- Outcome and performance indicators
- FLS Benefits Calculator

Underpinning the FLS Implementation Toolkit, is the FLS Benefits Calculator. This has been designed to estimate the benefits, in terms of reduced fragility fracture incidence and cost savings in the local health economy as a result of implementing an effective FLS.

Simply by entering the number of fragility fractures seen in your hospital(s) as inpatients or outpatients, usually derived from a local audit, the Benefits Calculator will output estimates of cost savings using validated empirical and study data. If you do not have audit figures the Calculator allows you to select your local population, using this to model the same outputs. The table below shows the benefits that would accrue over five years for a population of 250,000 with an age profile typical of that for England as a whole.

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<th>Year</th>
<th>Hip fracture (inpatient)</th>
<th>Other fracture site (inpatient)</th>
<th>Other fracture site (outpatient)</th>
<th>Clinical vertebral</th>
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<th>Average benefit per year</th>
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<td>£11,360</td>
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The Benefits Calculator is now available on line and can be accessed here: [http://benefits.nos.org.uk](http://benefits.nos.org.uk)

- **FLS Implementation Workshops**

The Workshops aim to enable and support the successful service development and commissioning of FLS by offering practical support to develop a service specification.
and present a business case. During the Workshop, attendees are given specialist support from clinical and commissioning experts using the resources within the FLS Implementation Toolkit.

- **FLS Champions’ Network:** [www.nos.org.uk/champions](http://www.nos.org.uk/champions)
This network aims to support the development of FLS across the UK, through providing a forum for sharing best practice and gaining knowledge and expertise in FLS and secondary fracture prevention. Through meetings and regular communications network members are kept up-to-date with all relevant work programmes related to osteoporosis and fragility fractures to enable the roll-out of FLS across the UK.

- **Peer Review:** [www.nos.org.uk/peer-review](http://www.nos.org.uk/peer-review)
Peer review involves the appraisal of services against agreed criteria to advance and develop clinical practice and service provision for the good of patients. The National Osteoporosis Society had developed a peer review process of osteoporosis and metabolic bone services, which includes an FLS if there is one. Peer review provides a means of assessing clinical care against agreed standards. It also addresses agendas of clinical governance, practitioner revalidation, and service development, with a view to facilitating all UK centres to develop a quality assured level of care for patients with osteoporosis and metabolic bone diseases. Peer review provides quality assurance to improve performance based around professional credibility.

- **Service Delivery Team**
In addition to the above resources, the National Osteoporosis Society have an experienced team who are able to offer bespoke support to those wishing either to set up an FLS from inception or for those wanting to develop their service further. Specifically, the team can support with the following aspects of setting up or developing an FLS:

1. Facilitation of engagement with key stakeholders to engender enthusiasm and commitment to developing an FLS.
2. Working directly with local stakeholders to project manage the commissioning of an FLS, from inception to launch, including development of the economic and business case; service specification; and resource and capacity planning.
3. Input to the development or review of any tenders or bids for an FLS.
4. Assistance with recruitment of the fracture liaison nurse (FLN) and clerical support, and provision of resources for training and induction of the FLN, utilising the Fracture Prevention Practitioner online training programme.
5. Providing input to enable the development of an FLS to meet the UK FLS Clinical Standards.
6. Helping to establish relevant protocols/care pathways for the service.
7. Supporting the engagement of all relevant stakeholders in primary and secondary care to ensure they are informed and involved with the service.
8. Working with commissioners to ensure services are sustained.
9. Establishing data collection and suitable methods of analysing, reporting and evaluating this.

For more information or to request support from the National Osteoporosis Society for developing or improving an FLS, please contact: Hilary Arden on: 01761 473112 or h.arden@nos.org.uk

4b. Metrics

Musculoskeletal Calculator
Arthritis Research UK has launched the Musculoskeletal Calculator, the first tool of its kind in the UK to give estimates on the prevalence of musculoskeletal conditions. See more at: http://www.arthritisresearchuk.org/policy-and-public-affairs/policy-priorities-and-projects/musculoskeletal-health-services/the-musculoskeletal-calculator.aspx#sthash.zWcZM3Yx.dpuf

British Orthopaedic Association Registries and outcomes
The role of registries & outcomes data collection is becoming increasingly significant, especially given the government’s increasing focus on the transparency agenda and the publication of individual surgeon outcome data. http://www.boa.ac.uk/pro-practice/publication-faq-2/

MSK Health Questionnaire

EQ5D self-reported patient measure for health status www.euroqol.org

The National Clinical Audit for rheumatoid and early inflammatory arthritis which was published in January 2016 also provides useful data and metrics in relation to these condition areas in particular (http://www.rheumatology.org.uk/resources/audits/national_ra_audit/default.aspx)
4c. Care standards to deliver high quality and integrated MSK services

1. NHS Outcomes framework - a set of national outcome goals and supporting indicators.
2. Commissioning outcomes framework - translates the NHS outcomes framework into indicators that are meaningful at CCG level.
3. Public Health outcomes framework - CCGs will work alongside local partners on health and wellbeing boards, including Directors of Public Health, to agree the Joint Health and Wellbeing Strategies and to reflect those strategies in their local commissioning plans.
4. The Adult Social Care outcomes framework - this has been further aligned with the NHS outcomes framework and the Public Health outcomes framework, supporting all parts of the health and care system to work together to support people to live better for longer.
5. Quality standards - CCGs must also have regard to Quality Standards produced by NICE as part of the Health and Social Care Act.

The Quality and Outcomes framework is an existing framework which incentivises quality care at GP level and is part of the GMS contract.

MSK–specific care standards
ARMA Standards of Care:
http://arma.uk.net/resources/standards-of-care/
British Orthopaedic Association Guidance and good practice:
http://www.boa.ac.uk/pro-practice/fipo-2/

MSK services framework 2006:
NICE guidance on MSK conditions:
http://www.nice.org.uk/guidance/conditions-and-diseases/musculoskeletal-conditions

This includes NICE guidance on:
Arthritis, Fractures, Hip conditions, Knee conditions, Low back pain, Maxillofacial conditions, Musculoskeletal conditions: general and other, Osteoporosis, Spinal conditions

4d. Resources for initial stages of network development

Business case

A business case template for a Fracture Liaison Service has been developed by the National Osteoporosis Society as part of the FLS Implementation toolkit. The template has been created by NHS professionals across the UK, making use of current policy and recognised best practice. The document is fully editable and is designed to save the time and trouble of researching, drafting and editing a document or workbook from scratch. The template can be found within the FLS Implementation toolkit: www.nos.org.uk/toolkit

Ealing CCG JSNA

Comparing apples with oranges: how to make better use of evidence from the voluntary and community sector to improve health outcomes. NHS Confederation, August 2014
http://www.nhsconfed.org/resources/2014/08/comparing-apples-with-oranges

Effective Networks for Improvement. Health Foundation, March 2014.
http://www.health.org.uk/publications/effective-networks-for-improvement/

Patient and public engagement exercises
Sheffield ‘Moving Together’ Musculoskeletal (MSK) services engagement report, November 2014.

v. Resources for change management

Aurum Institute - free resources and guides to implement health service quality improvements
www.auruminstitute.org/qualityimprovement
An appreciative inquiry approach to practice improvement and transformative change in health care settings.

Appreciative Inquiry (AI) – free resources using AI to implement change
https://appreciativeinquiry.case.edu

vi. Resources for Commissioning

British Orthopaedic Association - MSK Commissioning
http://www.boa.ac.uk/pro-practice/msk-commissioning-2/

Primary Care Rheumatology Society Commissioning Guide

British Society for Rheumatology Commissioning Toolkit for Providers
http://www.rheumatology.org.uk/includes/documents/cm_docs/2013/c/commissioning_toolkit_final.pdf

Commissioning and contracting for integrated care. The King’s Fund, November 2014

Beginning with the end in mind: how outcomes-based commissioning can help unlock the potential of community services NHS Confederation Briefing September 2014

All together now – making integration happen. NHS Confederation & Local Government Association 2014
http://nhsconfed.org/resources/2014/07/all-together-now

5. Background research: ARMA/ NHS England MSK Clinical Networks Project

Consultation – action research phase from ARMA/ NHS England April 2013 – October 2014

ARMA has a strategic partnership with the National Clinical Director for MSK disorders, and as part of this partnership ARMA ran an 18-month project to research, and then begin to implement, the best ways of supporting the development of MSK
clinical networks in England. Such networks have a key role in the new NHS landscape, especially in terms of driving up quality through the identification and dissemination of best practice.

The methodology adopted to structure the project was ‘appreciative inquiry’ which is a well-researched approach to change management which has been widely and successfully practiced in the public, private and voluntary sectors. The work included both extensive desk research on clinical networks and MSK services, and fieldwork, including interviews with:

- Patients and patient groups
- Specialist nurses
- MSK clinicians in primary and secondary care, who had pioneered innovative MSK service
- CCG MSK commissioners
- Senior managers in NHS England
- National Clinical Directors
- Allied Health Professionals
- Specialist and non-specialist GPs
- MSK academics and researchers

Further information on the project can be found here: [http://arma.uk.net/msk-clinical-networks-project/msk-2013-seminar-event/](http://arma.uk.net/msk-clinical-networks-project/msk-2013-seminar-event/)

5. NHS Confederation Consultation 2014-2015

In preparing this MSK Networks Resource Pack, extensive consultation was carried out during 2014-2015 with the MSK community, including: Patient groups and third sector organisations; selected CCGs across NHS England; MSK national working groups; MSK Community health trust senior management team; and the ARMA Clinical Networks Steering Group. Feedback on draft versions of the pack was also given on NHS Confederation website from members. Special thanks to Benjamin Ellis of Arthritis Research UK for allowing us to use his work on MSK incidence and prevalence, and Federico Moscogiuri of ARMA for his help in coordinating responses to the consultation, and in instigating the background research which underpins this pack. Thanks also to Ealing CCG and Pennine MSK for agreeing to be initial case studies, which will be added to on the online version of this resource.

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Calculated using hip fracture costings from\textsuperscript{1} updated using the Health Service Cost Index\textsuperscript{2} and Finished Consultant Episodes for hip fracture\textsuperscript{3,4,5,6}


\textsuperscript{iv} Department of Health (2009). Falls and fractures: Effective Interventions in Health and Social Care. Prevention Package for Older People.