EDITION 4 | WINTER 2019/20

JOINT MATTERS

VERSUS ARTHRITIS CLINICAL UPDATE FOR HEALTHCARE PROFESSIONALS

Welcome to the fourth edition of Joint Matters, the clinical update from Versus Arthritis. Joint Matters provides short, topical features from the world of MSK health, keeping you up to date with the latest clinical information, developments and conversation.

VERSUS ARTHRITIS

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All articles in Joint Matters share examples of ways to improve MSK care, however Versus Arthritis does not specifically endorse featured interventions over others that may available or are in development. This edition focusses on personalised care. Personalised care means people have choice and control over the way their care is planned and delivered. It is based on what matters to them and their individual strengths and needs.

The NHS Long Term plan aims to benefit up to 2.5 million people with long-term conditions by 2024, which will require healthcare professionals to adapt and deliver more personalised care. Articles in this edition are based on different models of personalisation.

WE ALSO WELCOME A NEW EDITORIAL PANEL TO THIS EDITION

We are delighted to be working with a new multi- disciplinary panel which is representative of the readership. Thank you to all of them for their guidance and support.

Louise Warburton
GP

Eddie Dandy
Superintendent Pharmacist

Jill Campbell
Nurse

AUTHORS FOR THIS EDITION ARE:

David Pilbury: Dave is a lead Physiotherapist and Clinical Specialist Physiotherapist in rheumatology at Pennine MSK Partnership, a committed advocate of shared decision making and an MSK Champion for Versus Arthritis. Based within a service renowned for personalised care, Dave leads projects for Quality Improvement centred around patient care, with a strong emphasis on nurturing a culture of shared decision making. He holds an Associate position with Advancing Quality Alliance (AQuA) and has been involved in clinical trials for the Option Grids for knee and hip osteoarthritis.

Charlotte Sharp: Charlotte is a rheumatology trainee in the North West. She is working on a PhD in 'knowledge mobilisation', getting research into practice, as time out of programme from specialist training (Business and Management at Alliance Manchester Business School). Her postgraduate certificate in Leadership and Service Improvement was awarded as part of a national clinical leadership fellowship. Bringing together her expertise in improvement and implementation with rheumatology, Charlotte led the development of the British Society for Rheumatology's Choosing Wisely UK recommendations.

Dr Jonathan Quicke: Jonathan is an Academic Clinical Lecturer in Physiotherapy with a specialist interest in people living with osteoarthritis. He holds a Clinical Research Network West-Midlands Research Scholar Fellowship and is based at the Primary Care Centre Versus Arthritis at Keele University. His clinical work involves the design, set up, delivery and evaluation of novel osteoarthritis clinical services and he has a back-ground in interdisciplinary pain management. He is part of the Keele implementation team embedding research evidence into clinical practice and is osteoarthritis clinical champion within a model osteoarthritis consultation implementation programme- JIGSAW-E. His osteoarthritis research focuses primarily on physical activity and weight loss and he enjoys collaborating widely, working with stakeholders and people with joint pain who share his passion. His PhD work on attitudes, beliefs and physical activity in older adults with knee pain was recognised internationally with awards from the Chartered Society of Physiotherapy and Osteoarthritis Research Society International.

Laura Swaithes: Laura undertook an undergraduate degree in Physiotherapy at Coventry University and graduated in 2004. Following this she worked at Nottingham University Hospitals NHS Trust on a general rotational post, before specialising in musculoskeletal physiotherapy. Laura has specific experience in complex musculoskeletal rehabilitation and orthopaedic caseload management across a range of healthcare settings.

In 2012-13 Laura completed the NIHR Masters in Research Methods at the University of Nottingham. Following this, Laura developed a clinical academic career by working at the Arthritis Research UK (ARUK) Centre for Sports, Exercise and Osteoarthritis alongside her clinical role. Laura gained research expertise working on the Injury and Illness Performance Programme with British Olympic Teams and then within the ARUK Pain Centre on a large project looking at knee pain and osteoarthritis in the community. Laura has also worked at the University of Nottingham in the School of Physiotherapy as a Clinical Link Tutor.

In 2014 Laura was awarded a clinical research internship; the Health Education East Midlands Silver Clinical Scholar Award (2014-15), and, the Chartered Society of Physiotherapy Education and Development Placement Award (2015-16), both of which supported her to develop as a clinical academic and to gain mentorship from world leading experts.

Laura started her PhD (entitled 'From research to primary care: a knowledge mobilisation study in osteoarthritis') at Keele University in 2016 and has recently secured an NIHR School for Primary Care Research Post-Doctoral Fellowship. Her work focussed on exploring the factors that influenced the implementation of an evidence-based innovation, and developing a toolkit to optimise knowledge mobilisation for OA in primary care. Laura gained further expertise in knowledge mobilisation following an NIHR Short Placement Award for Research Collaboration at UWE Bristol.

Dr Elizabeth Cottrell: Lizzie is a General Practitioner and Senior Lecturer in General Practice. Her PhD focussed on the attitudes and beliefs of GPs regarding clinical knee osteoarthritis. She has now taken this work forward into her post-doctoral research, in which her primary focus is the management of osteoarthritis in primary care. Lizzie has an interest in the delivery of services, both in terms of understanding healthcare professionals' behaviours, identifying effective service models and evaluating service delivery. Combining her academic and clinical expertise, she is a member of the implementation team at Keele University. Within this role she has co-led an international roll-out of an enhanced osteoarthritis care programme, focussed on improving uptake of guideline recommendations in primary care. Lizzie's portfolio of work provides the platform upon which she can help to bridge the gap between research evidence and real-world clinical practice.

Sarah Collis: Sarah is the CEO of charity Self Help UK and has more than 25 years' experience working in health and social care in community settings, working with volunteer and third sector organisations to tackle health inequalities and promote community empowerment and social justice. Self Help UK has been at the forefront of developing self-help group support for more than 35 years.

Rebecca Haines: Becky has been a GP partner at Glenpark Medical Centre in Dunston, Gateshead, since 2002 and has been Gateshead Clinical Lead for Diabetes NGCCG since 2014. She is also a Year of Care trainer and has helped to implement Year of Care (YOC) and support planning for patients with multiple long-term conditions across the CCG. She is an RCGP Champion for Collaborative Care and Support Planning.

Lindsay Oliver: Lindsay is National Director for Year of Care Partnerships and was a Consultant Dietitian in Diabetes in 2003. Lindsay has been involved in the development of self-care programmes both at a local and national level, including the development, research and roll out of both the DAFNE and DESMOND diabetes programmes. In addition, she has a major interest in communications skills and patient-centred care, including the development of innovative approaches to patient care. In recognition of her overall contribution to diabetes and long-term condition care she was awarded the prestigious Janet Kinson Lecture at the 2017 Diabetes UK conference.

SHARED DECISION MAKING AND BETTER CONSULTATIONS

David Pilbury, lead Physiotherapist and Clinical Specialist Physiotherapist in Rheumatology at Pennine MSK Partnership

When we talk about personalised care and shared decision making, we mean healthcare professionals making decisions alongside people living with long-term conditions. It involves identifying what is most important for each individual to enable them to live the life they want to live. This then enables health and care services to be designed and co-ordinated around an individual's needs.

Shared decision making (SDM) is appropriate in almost every healthcare setting where a decision is said to be "preference sensitive." This includes areas where treatments involve trade-offs between risk and benefit, quality and length of life or where there is little clear evidence between options.

This resource, produced by AQuA (right), an NHS health and care quality improvement organisation based in the North West beautifully frames this 'preference sensitive' scenario; one that our colleagues and patients potentially face many times a day. As patients we want and need to know more in order to make a decision that is right for us. As clinicians we know that more than just medical information goes into influencing this type of decision; a person's feelings, beliefs and values will also play a significant role in determining the outcome. What matters is not always obvious. Values vary widely – far more than we expect. As clinical 'experts' we can consistently present the latest clinical evidence but, without ascertaining the individual's values and factoring these into the decision making process, how can we be sure that we have done our best to support a person in reaching the right decision for them?

So how, in a clinical setting, can we best determine what a person's feelings, beliefs and values are? Quite simply by asking. This is a fundamental element of good consultation skills but too often is forgotten.

IT'S YOUR DECISION...

Imagine you have developed early symptoms of a potentially fatal disease.

NICE have approved two possible treatments:

TREATMENT A – gives you a guaranteed period of remission, but no cure.

TREATMENT B – gives you a 50/50 chance of kill or cure.

Your decision – how long a period of remission would you want from Treatment A to choose that treatment, rather than go for the 50/50 kill or cure from Treatment B?

Bill Fulford, AoMRC & Ashok Handa, National Centre for Values Based Practice, Oxford University

Courtesy of AQuA

SDM can help to overcome these issues by creating a new relationship between individuals and professionals based on partnership. The National Patient Survey showed that over the past 15 years around 30% of patients want more involvement in managing their care. SDM works on the principle that every patient contact is the meeting of two experts. The clinician brings knowledge of diagnosis, cause of disease, prognosis,

treatment options and outcome probabilities. The patient brings experience of illness, social circumstances, and attitude to risk, personal values and preferences. The survey states that:

"patients involved in decisions about their care have fewer regrets about decisions, report better relationships with clinicians, adhere better to treatment; and report a better experience including more satisfaction with the outcome".

In other words, SDM has a fundamental impact on the safety and effectiveness of personalised care as well as reducing waste in the system.

Patients who are empowered to make decisions about their health that better reflect their personal preferences often experience more favourable health outcomes. This can include being less anxious, experiencing a quicker recovery and increased compliance with treatment regimes. This has been shown by the AQuA (Advancing Quality Alliance) programme where teams that have implemented SDM have seen improvements in health indicators across a variety of areas.

One of the key aspects of SDM is effective communication from both the clinician and patient. Their level of health literacy as well as an ability to convey the clinical information in a way that is meaningful and understandable is essential for a patient to make a decision about their treatment. Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. It plays a significant part in the understanding and interpretation of the information and there are significant links between lower levels of health literacy and poorer health outcomes.

The role of the system and leadership

There are a number of key policy drivers for SDM including the NHS Long Term Plan, Universal Personalised Care, the Health and Social Care Act (2012) and the NHS Constitution (2015) to name a few.

In practice, involved patients and prepared professionals need to have a system around them that supports the use of SDM for maximum success. A supportive system might include;

- appointment systems that allow opportunity for decisions to be discussed and reviewed or revisited – not always face to face necessarily but using telephone or email too. This **MUST** include time to think about and discuss the options with the important people around them.
- a variety of information systems that make it easy to provide patients with decision support
- patient record systems that enable shared decisions and patient preferences to be documented
- evaluation systems that allow staff to measure how well they are involving patients with decisions, what decisions patients are making (especially useful for commissioning the appropriate levels of service) and how the service as a whole is being impacted.
- the provision of health literate patient information which meets people's functional literacy and numeracy.

A prepared public

Traditional health care has tended to be paternalistic; making decisions for other people rather than letting them take responsibility for their own lives. Moving away from this paternalistic culture is key and involves changing our thoughts and actions as both clinicians and patients. This can be supported by information in waiting areas and encouraged by the behaviour of healthcare teams during the current appointment and in the future appointments.

Useful Tools include:

- Ask 3 Questions (AQuA)
- BRAN (Choosing Wisely UK)
- Agenda setting tools included in patient's appointment information

Motivational interviewing

Even professionals who strongly support the ethos of SDM report that it can be difficult to put into practice in busy clinical settings or complex situations. Motivational interviewing can help teams take a positive approach to care and support the SDM process. It offers a set of principles and skills that can help health professionals communicate with their patients, both to engage them in the conversation generally and to help elicit their values and preferences in relation to a specific decision.

Teach Back

The Teach Back method is a useful way to confirm that the information you provide is being understood by getting people to 'teach back' what has been discussed and what they have been asked to do. This is more than saying 'do you understand?'. It is a check of how you have explained things, not of patient comprehension. It is particularly useful with people who have lower levels of health literacy and could be a useful tool as part of a SDM conversation.

Measuring the impact of shared decision making

There are several tools that can be used to measure SDM in consultations. CollaboRATE is simple to use and rates the patients view of their involvement in decisions about their care. SDM Q-9/SMD-Q-DOC as well as the GP Patient Survey Item 28 can be useful and are relatively straight forward to administer.

Observer OPTION 5 can be a little more time consuming to administer- requiring an observer to score the clinician but the depth and quality of the information it produces can be extremely useful. Clinicians are scored on the clarity and quality of their consultation including their active listening, reflection as well as the clarity of the information presented to the patient conveying risk and options of treatment in an unbiased way. There are some advantages in using platforms such as the Sharp Network where the assessment is performed by an expert observer outside of the organisation where balanced and unbiased review can be offered. Simple patient satisfaction rating and stories are also powerful tools to convey information to teams.

SDM is a key part of my day to day practice. We make decisions about the food we eat, the music we listen to and the journeys we make every day. We base this on our opinions and the information available to us. How can we expect patients to make decisions about their care without offering them the information they need to weigh and judge? Our role then is to actively involve patients in making informed decisions about their own care, in turn improving their confidence and compliance and ensuring that the patient-clinician relationship is one of partnership.

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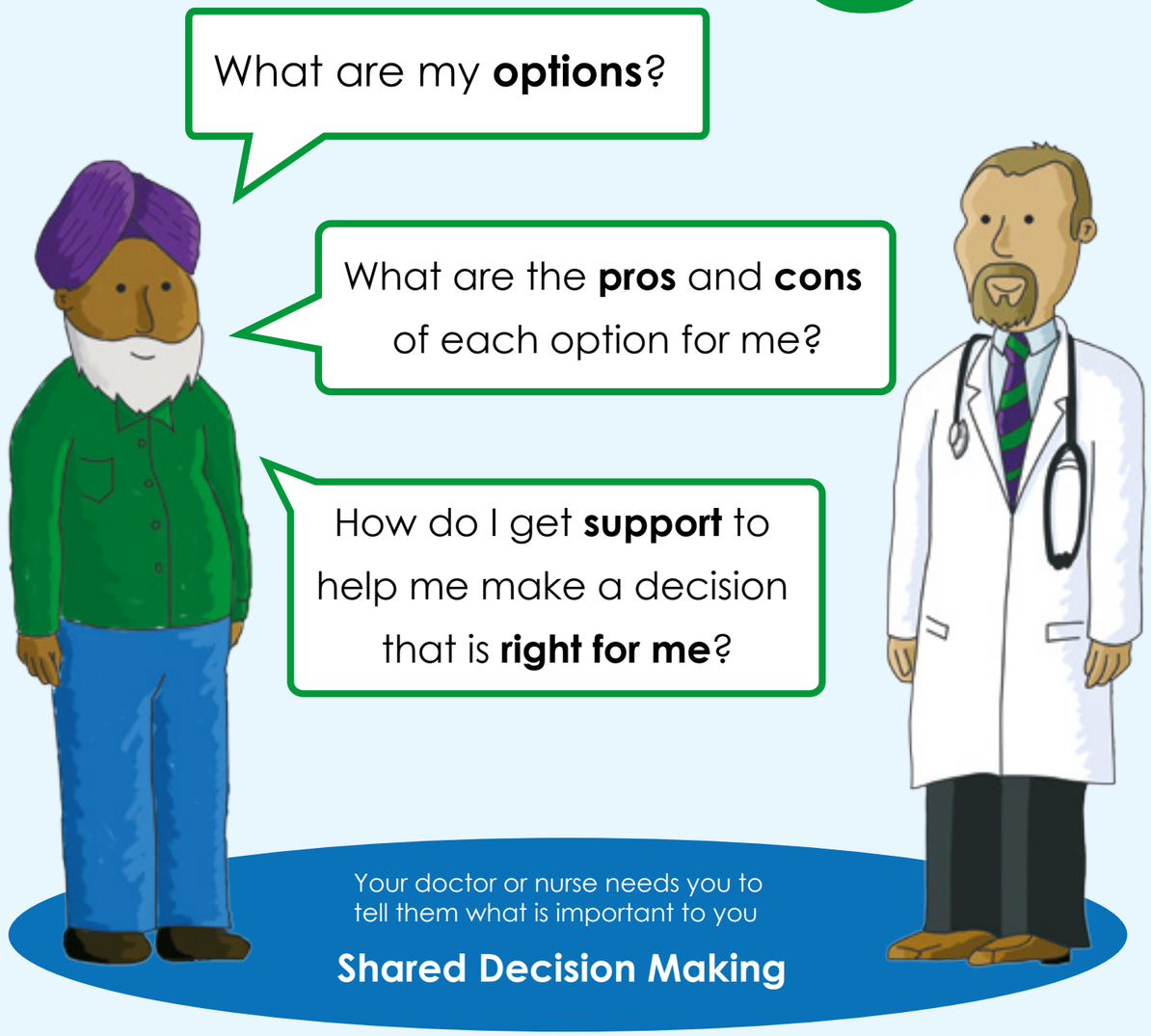
1. *www.sharpnetwork.org*
2. *https://www.england.nhs.uk/shared-decision-making/guidance-and-resources/*
3. *http://www.choosingwisely.co.uk/resources/shared-decision-making-resources/*
4. *https://www.aquanw.nhs.uk/*

Ask 3 Questions

Normally there will be choices to make about your healthcare. Make sure you get answers to these three questions:



Credit: aquanw.nhs.uk/

AQuA Advancing Quality Alliance

Right Care Shared Decision Making Programme

NHS

ENABLING BETTER CONVERSATIONS – THE CHOOSING WISELY INITIATIVE

Charlotte Sharp, Rheumatology Trainee, North West

Choosing Wisely is an initiative aiming to reduce unnecessary tests and treatments by promoting shared decision making conversations between patients and healthcare professionals. With better dialogue between doctors and patients and more efficient use of tests, procedures and treatments, there is less burden on the patient, administration for clinicians and the opportunity to make the most of available resources.

The British Society for Rheumatology (BSR) Choosing Wisely UK working group included patients, rheumatologists, nurses, immunologists and a GP. An abbreviated Delphi process was used to develop the recommendations. Our rigorous and transparent process was commended at the launch in June 2018 by the Academy of Medical Royal Colleges, which coordinates the UK campaign.

What are the BSR Choosing Wisely UK recommendations?

The BSR recommendations on the diagnosis and management of rheumatological conditions build upon existing practice. They aim to promote evidence based, pragmatic and patient centred care for patients. There are separate versions for patients and healthcare professionals, both of which are housed on the Choosing Wisely UK website, along with others from complementary medical specialties such as radiology: **choosingwisely.co.uk**

Recommendations regarding diagnosis of rheumatoid arthritis (RA) and connective tissue diseases include ANA, RF and ACPA. They focus on the importance of testing for these antibodies only when there is a strong suspicion of rheumatic disease, as positive results can exist in healthy people. Whilst these tests may aid diagnosis, they must be considered in line with the overall clinical picture. For example, use of RF/ACPA for blanket screening to rule a diagnosis of (RA) in or out, should be avoided, and instead a referral to rheumatology should be made urgently. Immunological tests such as complement C3, C4 and double-stranded DNA which are used to monitor connective tissue diseases are recommended to be reserved for specialist use.

The recommendations regarding treatment focus on bisphosphonates, vitamin D, and steroid injections for non-inflammatory musculoskeletal conditions, and may all be relevant to patients with inflammatory and/or osteoarthritis. They reinforce the importance of reviewing therapy for those on bisphosphonates for 3-5 years, (which led to one of our patient contributors raising this with her GP and securing the first review of hers after 10 years!). The importance of us all taking vitamin D supplements during winter is highlighted, something which I try to adhere to myself. Finally, the recommendation for non-inflammatory arthritis simply highlights the need to offer patients all the information they need regarding the benefits and risks of injection therapy, as well as the importance of physical therapy and exercise. Although these topics are, and will likely continue to be, subject to nuanced debate, we hope our recommendations provide pragmatic guidance for the majority of patients.

Topic	Our Clinician Recommendations
ANA & ENAs	Testing ANA and ENAs should be reserved for patients suspected to have a diagnosis of a connective tissue disease, e.g. lupus. Testing ANA and ENAs should be avoided in the investigation of widespread pain or fatigue alone. Repeat testing is not normally indicated unless the clinical picture changes significantly.
RF & CCP/ACPA	Patients with suspected inflammatory arthritis should be referred to Rheumatology without delay. Rheumatoid factor and CCP/ACPA are important, but should be avoided as screening tests. A negative result does not exclude rheumatoid arthritis, nor does a positive result equate to a diagnosis of rheumatoid arthritis. Repeat testing is not normally indicated.
Vitamin D	Everyone should consider Vitamin D supplementation during winter. People who have restricted access to sunlight (e.g. those living in institutions or who cover their skin), or have dark skin, should consider supplementation all year round. Vitamin D testing should be reserved for people at high risk from deficiency and avoided as part of routine investigation of widespread pain alone. Repeat testing is not normally indicated in those taking supplements.
Bisphosphonates	Bisphosphonate therapy should be reviewed with every patient after 3-5 years, and a treatment holiday considered. This should follow a shared-decision making conversation which includes the risks and benefits of continued treatment.
Steroid injections for non-inflammatory musculoskeletal conditions	The use of intra-articular and soft-tissue steroid injections for non-inflammatory musculoskeletal conditions should be preceded by consideration of non-invasive alternatives such as exercise and physical therapy. Consent to any invasive procedure such as this must arise from a shared-decision making conversation with every patient, which includes assessment of the risks and benefits.
C3, C4 & dsDNA in connective tissue disease	C3, C4 and dsDNA are important tests to help in the diagnosis and assessment of disease activity in lupus. They should be reserved for specialist monitoring of disease activity and should be avoided as screening tests.

Source: https://www.rheumatology.org.uk/news-policy/details//Implementing-Choosing-Wisely-UK-recommendations-in-rheumatology

How can we implement the recommendations?

As healthcare professionals, we can influence change in a number of ways. Most importantly, empowering patients to ask questions important to them, aiding shared decision making. Secondly, by raising awareness of the recommendations amongst colleagues, presenting them at departmental meetings and using them as a teaching aid for students and healthcare professionals in primary and secondary care. With this in mind, our team have collaborated with organisations such as Versus Arthritis, National Rheumatoid Arthritis Society (NRAS), Arthritis and Musculoskeletal Alliance (ARMA) and the Royal College of General Practitioners (RCGP) to raise awareness, performing webinars, writing patient articles, and incorporating them into the RCGP's Inflammatory Arthritis Toolkit: **rcgp.org.uk/clinical-and-research/resources/toolkits/inflammatory-arthritis-toolkit.aspx**

We have presented the recommendations to the BSR conference and at lots of departmental rheumatology meetings, as well as at two national immunology conferences, where they have been very well received. Thirdly, using them as the basis for quality improvement work, auditing current practice and implementing locally agreed changes to, for example, reduce the number of patients with suspected RA awaiting immunology tests prior to referral to secondary care. Finally, organisational change including alterations to order sets in immunology and IT alerts can be effective, as long as they are implemented in collaboration with all interested stakeholders. Immunology colleagues appear keen to collaborate to help reduce unnecessary testing at several sites. The challenge is now on for us all to ensure we perform best practice ourselves, and help support colleagues and patients in reinforcing these pragmatic recommendations.

SUPPORTING PEOPLE WITH OSTEOARTHRITIS IN PRIMARY CARE TO MANAGE THEIR CONDITION

Jonathan Quicke, Academic Clinical Lecturer in Physiotherapy, Keele
Laura Swaithes, Physiotherapis and Clinical Academic Research Fellow, Keele
Elizabeth Cottrell, GP and Senior Lecturer in General Practice, Keele

KEEPING MOVING IS A KEY PART OF MANAGING OSTEOARTHRITIS

Osteoarthritis (OA) is a joint condition which typically occurs in those aged 45 years and older, although it can affect younger people. It causes activity related joint pain, stiffness and loss of function in the affected joints. It is the most common type of arthritis and over 8.75 million people in the UK have presented to primary care with OA. OA care can vary between healthcare practitioners and treatment may not consistently be in line with evidence-based recommendations.

People with OA may hold misconceptions about the condition, such that it is normal with ageing, will inevitably deteriorate and that little can be done to help it. These beliefs may affect how people manage their condition and can result in patients not returning to primary care for follow-up once they have been diagnosed, if they present at all. However, there is a lot that can be done to help the condition, including effective core treatments (exercise and weight loss, if needed) and adjuvant treatments which can help to reduce pain and improve function.

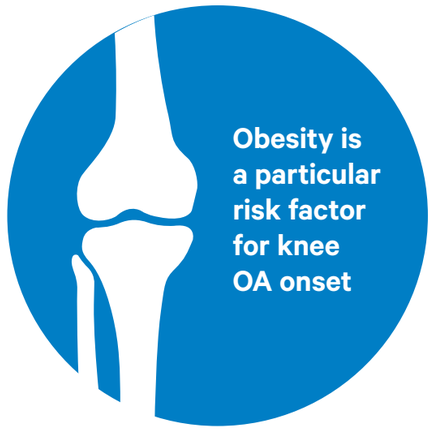
What does self-management look like for people with osteoarthritis?

> **NHS England define self-management as the "actions taken by people to recognise, treat and manage their own health. They may do this independently or in partnership with the healthcare system"** *(https://bit.ly/2LKiYes)*.

Many different healthcare practitioners can support self-management in primary care and there are different care pathways and entry points for people to access care and support. For example, people with osteoarthritis may consult to a GP, primary care nurse, first contact practitioner physiotherapist, physician associate or pharmacist.

A clinical assessment and diagnosis of OA is the first step in supporting people with OA to access further information about their condition. It is important to explain OA in such a way that encourages and contextualises the need for and value of self-management. Most people with OA have fluctuating symptoms with better periods and times when their pain may flare up but deterioration in symptoms over time is not inevitable. Giving realistic and positive messages about the condition alongside advice regarding effective approaches that can help to manage symptoms and improve function is important and valued by affected patients.

The number of people in the UK who have sought treatment for osteoarthritis is **GREATER** than the population of New York City



People who combine diet with regular exercise may be more likely to maintain weight loss and achieve clinical benefits

Healthcare practitioners can provide advice regarding appropriate physical activity and explain the benefits of undertaking both muscle-strengthening and aerobic exercises. It is useful to acknowledge that exercising can be uncomfortable initially and to provide patients with strategies to manage this. Research evidence is clear that keeping active and regular therapeutic exercise is both safe and can reduce pain and improve functioning for people with OA. High quality written information provision such as the freely available Versus Arthritis "Keep moving leaflet" and the Keele "Osteoarthritis guidebook" can be given to support verbal advice. Activity recommendations should be tailored to the individual's baseline ability, preferences and local community opportunities.

> **People with OA who are overweight or obese may further help their condition through managing their weight.**

Obesity is a particular risk factor for knee OA onset and progression. Asking permission to discuss lifestyle factors that may help OA is one way of opening a discussion around weight and clinicians should be mindful of adopting a stigma-free manner when discussing the benefits of managing weight. Factors contributing to weight gain are complex but exploring previous strategies that may have been effective in managing weight in the past, providing appropriate information such as healthy eating advice and advice regarding online NHS services and local weight loss services are ways of supporting weight management.

In addition to the core non-pharmacological ways of managing OA other adjunct options include appropriate footwear (with thick soles, no raised heel and soft uppers), the use of ice or hot packs, transcutaneous electrical nerve stimulation (TENS) and walking aids as required.

First line adjunctive over-the-counter pharmacologic treatments that can help with symptomatic pain relief include topical non-steroidal anti-inflammatory drugs (NSAIDS) and paracetamol. Topical NSAIDS work best for more superficial joints such as hand and knee joints and are generally safe apart from occasional skin reactions. Topical capsaicin can be helpful in the managing of superficial joints also. If insufficient relief is obtained from these approaches, the pharmacological management can be stepped up to oral NSAIDS and/or opioids. However, the benefits of these approaches need to be carefully balanced against the risks when commencing and continuing these medications.
If oral NSAIDS are used, it is recommended that a co-prescription of a gastroprotective agent is used.

CASE STUDY 1

Joint Implementation of Guidelines for Osteoarthritis in Western Europe (JIGSAW-E)

The JIGSAW-E project is an implementation project that translates innovations developed through research, to support the delivery of NICE OA guidelines into real world clinical practice, with the aim of improving quality of primary care for OA.

The project is led by the Impact Accelerator Unit at Keele University who have brought together a community of practice of clinical academics, researchers and people with joint pain including the UK and five other European countries. Patient and Public Involvement and Engagement (PPIE) has been central to this process and has helped to shape the roll out of JIGSAW-E.

The four key innovations implemented in JIGSAW-E are:

1. An OA guidebook written by patients and health professionals for patients
2. A model OA consultation for primary care, using an electronic OA e-template to guide practice
3. Training for general practitioners, practice nurses, physiotherapists and pharmacists to deliver the model consultation
4. The development of measures of quality care.

Resources describing the JIGSAW-E model and its associated materials are freely available (see links below):

http://www.keele.ac.uk/media/keeleuniversity/ri/primarycare/pdfs/OA_Guidebook.pdf

http://www.jigsaw-e.eu/

A model OA consultation

CASE STUDY 2

ESCAPE-pain

ESCAPE-pain is a rehabilitation programme for people with persistent joint pain of the knees and/or hips, that integrates educational self-management and coping strategies with an exercise regimen individualised for each participant. It helps people understand their condition, teaches them simple things they can help themselves with, and takes them through a progressive exercise programme so they learn how to cope with pain better.

Robust evaluation shows that ESCAPE-pain:

- Reduces pain
- Improves physical function
- Improves the psychosocial consequences of pain
- Reduces healthcare and utilisation costs.

Versus Arthritis has worked in partnership with Health Innovation Network to help reach more people with arthritis. ESCAPE-pain can now be found in over 240 locations across the UK, with nearly 1000 facilitators trained and an estimated 14,000 people with arthritis have benefitted from the programme.

https://escape-pain.org/

Patient's perspective on ESCAPE-pain

"[Pain] It's not dominating and spoiling my life anymore."
ESCAPE-pain participant

"I'm feeling good, better than I was and it's all through exercise. My diabetes is under control and I have lost some weight. I have improved the strength of the muscles in my leg."
ESCAPE-pain participant

Professional's perspective on ESCAPE-pain

"From a physiotherapy point of view ESCAPE-pain is a no brainer....it is evidence based, cost effective and patients and facilitators like it. I was blown away by the outcome measures and feedback from the first groups we delivered, it really does work!"
Senior Physiotherapist

"Clearly defined model, with proven success for patients and proven financial impact...were key factors for implementing ESCAPE-pain."
Commissioner

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SOCIAL PRESCRIBING: A SIGNIFICANT OPPORTUNITY FOR EVERYONE?

Sarah Collis, CEO of Self Help UK

Kings Fund definition: Social prescribing, sometimes referred to as community referral, is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. Recognising that people's health is determined primarily by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health.

Social prescribing schemes can involve a variety of activities which are typically provided by voluntary and community sector organisations. Examples include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports.

Social prescribing may not be a new concept to you, in fact many areas across the UK have been running support services that engage patients in actively participating in the management of their health and care for several years. However, with the introduction of social prescribing within the NHS Long Term Plan and its inclusion in the 2019 GP contract, social prescribing will soon be everywhere. So now is the time to get familiar with a whole range of services designed to support patients and carers to address the wider determinants of health, improve health behaviours and better manage their conditions.

Social prescribing schemes promote non-medical interventions that address wider determinants of health and help to improve patients' health behaviours and management of their condition(s).

In England, the NHS Long Term Plan states that nearly one million people will qualify for referral to social prescribing schemes by 2023-24. Primary Care Networks (PCNs), announced as part of the 2019 GP contract, will be funded to employ one social prescriber each from 2019[1]. This is welcome news to the supporters of personalised care and wider integration of health, social care and the voluntary, community and social enterprise sector (VCSE). Models of social prescribing vary and can be used to target specific demographics, such as student health, cancer, mental health, loneliness and isolation, long term conditions. The models and areas of focus chosen are dependent on local priorities and specific impacts of wider determinants of health. Based on population health statistics, new PCNs are being established to manage the health of up to 50,000 patients in a locality. Establishing social prescribing schemes based in the heart of communities is hoped to manage increasing demand on primary care and to establish links with the local VCSE providers.

Social prescribing is coordinated by 'Social Prescribers or Link Workers' whose role it is to triage patients referred through general practice, healthcare professionals,

BY 2023-24 NEARLY ONE MILLION PEOPLE WILL QUALIFY FOR REFERRAL TO SOCIAL PRESCRIBING

mental health services and a range of routes depending on the specifics of the scheme. Some social prescribing schemes involve health coaches who support patients to identify goals which result in better health outcomes and behaviour changes.

You may not be aware of the diversity of services and support available to your patients that are delivered by the VCSE in your local area. Services delivering the 'social cure[2]' that will, it is hoped, provide an answer to an increasing demand on primary, community and secondary care. This is a tall order for any provider but for the most under-resourced sector within the health economy, it's particularly challenging.

Don't get me wrong, I really welcome the idea of the VCSE being part of a wider, integrated health and care system. After all, the interventions, support services and impact they deliver have been helping to improve the lives of patients for many decades.

My sector is the one that jumps in when the market fails; when there is no profit in it for the private sector and when public funds are just too stretched to reach those who have complex needs and issues associated with the wider determinants of health inequality.

We have been here for years, working with the most marginalised, being powered by volunteers and alongside passionate sector professionals. But now with a national focus on social prescribing the VCSE is about to take centre stage in the fight to reduce the demand on and cost of health to NHS services. However, as with many new initiatives, the hype can often exceed the reward and whilst it is my hope that we are entering a new era of greater collaboration and integration, the risks to the VCSE are significant. Placing the weight of change onto the VCSE and asking us to deliver without guaranteed funding, infrastructure support and parity with our health colleagues is indeed already a reality in some areas.

We may indeed save costs in our NHS but let's not lose sight of the fact that the VCSE may be powered by volunteers, but it is never free, only free at the point of access...sound familiar?

So, how can we ensure that social prescribing succeeds?

As the CEO of Self Help UK[3], a small charity working with peer support groups, I have started to see the tussle and tension that can emerge when multiple agents and very different sectors are brought together within these new schemes. Where they are successful, PCN leads have embraced the idea of integration with the VCSE not seeing them as the 'bolt on' service but truly integrating into care pathways for a range of long-term conditions. This means considering the funding and resource implications of increased demand on VCSE services within the design, planning and budgeting of PCNs.

In Nottinghamshire, where my charity is based, social prescribing has been evolving over the last two years, new Link Workers are imminent as the PCNs take shape. As these plans grow, we continue to innovate and look at ways in which we can work with our health colleagues to achieve the best outcomes for people and to promote peer support groups as a way to add value to existing NHS services. For example, Self Help UK is currently working with patients affected by MSK conditions and the associated mental health issues who are employed within the construction industry. Together with our community NHS provider colleagues, we are taking a holistic approach to provide ongoing and sustainable support for individuals whose livelihood depends on their ability to undertake manual labour. Getting it right for these patients is a joy to behold; this has involved a mix of physical exercise, physiotherapy and occupational therapy and a peer driven health management programme which has developed into sustainable peer support groups.

Peer support can have a profound impact on people affected by a long term health condition. Being with a group of people who have faced the same issues as you is invaluable; people who have found their way through the maze of services, advice, information and challenges to get the care they need. Together they learn from each other, build their confidence in managing their health and wellbeing and see hope through the progress of others. Many health charities host and develop peer groups and provide a vital link to health professionals who offer advice, support and reassurance. Some of these groups go on to be self-sustaining; successfully fundraising and maintaining relationships with local health professionals and networks. These independent groups, together with charity enabled peer support groups are an integral part of new social prescribing schemes.

Bringing health and social care professionals together with the VCSE professionals and volunteers to provide a truly holistic approach to self-care and self-management is the ambition of many who have worked to ensure patients and carers receive a truly personalised approach to health care.

As social prescribing comes to an area near you soon, I hope that you can fully engage in supporting your patients to take up the offer of exploring social prescriptions for VCSE led activities. The potential wealth of knowledge and support at your disposal through this new initiative is worth investigating. Building relationships with local charities, community development projects, walking clubs, men in sheds projects and a whole host of other initiatives can not only enhance your patient's experience of care, but also yours. Witnessing people who are struggling to manage their long term health condition thrive when connected with others to work through the same challenges is not only empowering but inspiring.

Building the evidence base for integrated services for patients and carers is crucial to the future of our health and wellbeing in the 21st century. Let's hope that this new collaboration with the VCSE is just that, a multi-disciplined approach to empowering people to be better equipped to manage all aspects of their health and wellbeing within a supportive and collaborative environment in which the patient is the most important partner.

1. *https://www.england.nhs.uk/personalisedcare/upc/*
2. *The 'Social Cure' (Jetten, Haslam, & Haslam, 2012)*
3. *www.selfhelp.org.uk*

Across the UK, passionate and dedicated Versus Arthritis volunteers run over 500 local groups, bringing people with arthritis together to share their experiences and access face-to-face support.

"I wouldn't have followed up with my physical activity sessions if I'd not been to the workshop. I was suffering with pain and after five sessions with the physio doing those exercises, I no longer get [the pain] and I have also been taking less medication"

Living well with arthritis participant.

To find out what is available to help support your patients, please visit: www.versusarthritis.org/get-help/

CARE AND SUPPORT PLANNING FOR PEOPLE WITH JOINT, BONE AND MUSCLE CONDITIONS

Rebecca Haines, GP partner, Glenpark Medical Centre, Dunston, Gateshead
Lindsay Oliver, National Director for Year of Care Partnerships

In 2014 Versus Arthritis produced a report 'Care Planning and Musculoskeletal Health' which highlighted the need to develop a practical approach to the delivery of care and support planning so that it included people with joint, bone and muscle conditions. Currently only 12% of people with musculoskeletal conditions have a care plan, but many more could benefit. We want to see everyone with arthritis being offered care planning to help them take control of their condition and improve their quality of life.

Over the last three years Versus Arthritis has supported Year of Care Partnerships (YOCP) and five GP practices who were already implementing care and support planning (C&SP) to include people with joint, bone and muscle conditions into annual C&SP. This was for people with single joint, bone and muscle conditions such as fragility, osteoarthritis or back pain or for those conditions alongside the other long term conditions they live with such as diabetes or COPD. The learning from the study has been collated into a final report "Bringing MSK Conditions In From The Care Planning Cold – A Feasibility Study Final Report June 2019" which can be viewed at **https://bit.ly/2NXwUDF**.

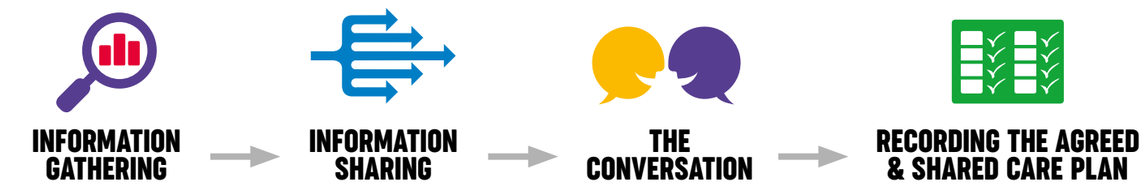
The findings from this report highlight the unmet need of people with joint, bone and muscle conditions and the prominence that pain has in people's lives. It also gives hope that this person-centred approach allows people to express what is important to them as well as being able to better access the information and support they need. The C&SP approach was well liked by clinicians and the people who took part, but it does expose a need to build confidence and training amongst those working in primary care.

What is care and support planning (C&SP)?

C&SP is about enabling better conversations between people living with long term conditions (LTCs) and health care professionals (HCPs) that are focussed on the personal priorities of the individual, so that support and services can be tailored to each person. C&SP has five core components (preparation, conversation, recording, actions and review) which all need to be in place for it to be effective. This requires changes to staff values and skills alongside changes to general practice infrastructure. See *Figure 1. Care and support planning: the process.*

Year of Care Partnerships is an NHS organisation which has been working for the last 13 years to develop expertise and an implementation approach to the practical delivery of care and support planning for people with long term conditions. They can be contacted at: enquiries@yearofcare.co.uk

Figure 1. Care and support planning: the process



C&SP differs from traditional care. To enable a 'more meaningful conversation' the person is actively prepared to be an equal partner in their care. This includes the GP practice sending reflective preparation prompts and sharing relevant assessments and test results with the person ahead of a C&SP conversation with the healthcare professional.

Becky Haines, lead GP for the project at Glenpark Medical Centre, describes her experiences of delivering this approach within her practice:

"We had already set up a single C&SP approach for people with single and multiple QOF conditions such as diabetes, respiratory conditions and heart disease. Many of those people had joint, bone and muscle conditions and we began to notice that the C&SP approach often meant that people with conditions like diabetes wanted to talk about their joint, bone and muscle condition as it was usually the thing that most affected their daily living. As part of this study we formally invited people with joint, bone and muscle conditions alongside other LTCs and also people with joint, bone and muscle conditions alone. This group was not part of our usual recall system and so had never been invited to attend a planned appointment before; their care had mainly been reactive.

We found that people were keen to discuss their joint, bone and muscle conditions and how their lives were affected by it. Many people stated that they usually *"just got on with it"*, *"I didn't think there was anything you could do"*. Although some patients had developed fantastic self-management skills, others had been held back by the way their condition had been described to them by healthcare professionals (HCPs). For example, patients who had been taking treatment for osteoporosis for years didn't think they could exercise as their *"bones are fragile"*, and patients with severe osteoarthritis who had been told years ago it was *"just wear and tear"* were under the impression that there was nothing that they could do.

As part of the project we had training in how to support people to live with their joint, bone and muscle conditions including pain management, especially non-pharmacological approaches, which gave me much more confidence to discuss pain with people.

CURRENTLY ONLY 12% OF PEOPLE WITH MUSCULOSKELETAL CONDITIONS HAVE A CARE PLAN, BUT MANY MORE COULD BENEFIT.

I was surprised by how many people were keen to reduce their prescribed analgesia and try other ways to manage pain, although there were some individuals who needed pharmacological options as part of their management.

Using the Year of Care approach meant that patients had time to reflect on their life and health prior to their appointment and had considered what was important to them at that time, which was the focus of the conversation. We used our social prescribing network to signpost patients to relevant exercise classes, groups, local support when appropriate, and offered referral to occupational therapy or physiotherapy if needed.

There is no doubt in my mind that people with joint, bone and muscle conditions are a neglected group within the healthcare system, and also that healthcare professionals in primary care would benefit from more training especially with regards to the words we use to describe joint, bone and muscle conditions and the use of non-pharmacological pain management techniques."

Key learning from the study

- The core components of C&SP (using the Year of Care Partnership approach) are suitable for people living with joint, bone and muscle conditions and including those conditions formally into the C&SP process enabled musculoskeletal topics to be discussed more easily.
- At least half of those living with joint, bone and muscle conditions have other long term conditions, and we were able to show how issues relating to those conditions can be included effectively and efficiently in a multimorbidity approach.
- The C&SP process, which includes a preparation step, enables previously undisclosed topics related to symptoms, daily living and overall function in joint, bone and muscle conditions to be raised, discussed and recorded, revealing a large amount of remediable unmet need.
- People reported a wide range of positive benefits including learning more about their conditions, significant behaviour change and involvement in new activities which in some cases were life changing.
- Pain was consistently a major theme for people with joint, bone and muscle conditions, and practitioners needed support and training to feel confident in discussing approaches to living with pain.
- Tailored training in musculoskeletal specific issues was needed and proved effective in addressing staff knowledge and confidence.
- The C&SP conversation acts as the pivot which moved the focus of ongoing support towards activities in the community rather than relying solely on medicines and traditional services.

Patient's perspective of care and support planning

"Totally thrilled, I have been out of the house by myself for the first time in years."
Person with MSK condition

"Fantastic. Getting the yellow form made my day. Able to talk about everything I wanted and make plans for better health."
Person with MSK condition

"You go to the doctor's usually for a specific reason but there's often something else that you want to mention, but you never get around to it. I just love the fact that this paper asked me how I was coping and more or less asked me what I was doing with my life... And I just love the fact that everything I wanted to say was down on paper, so it was there to be brought out. I just thought it was fabulous!"
Person with MSK condition

Professional's perspective of care and support planning

"Care and support planning creates happier teams."
GP

"... it's massively appreciated. Patients are used to their joint problems being ignored. There's no doubt it's been of benefit."
GP

"It feels like a new channel of communication has been opened."
Nurse practitioner

FOR HEALTHCARE PROFESSIONALS

- **Core Skills in MSK Care**
  an educational programme aimed at helping GP's 'get the basics right' in Musculoskeletal consultations.

- **MSK Champions**
  a leadership programme aimed at any one designing, developing or working in an MSK service with an idea for service change.

FOR YOUR PATIENTS

- **Patient information booklets**
- **Virtual assistant**
- **Helpline 0800 5200 520**
- **UK wide support services**
  for people of all ages including young people and children.

For more information please visit our website versusarthritis.org

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This is your update so please do tell us what you like and what you'd like to see more (or less) of. If you would like to contribute to the next edition please do get in touch with us: professionalengagement@versusarthritis.org