

Meeting of the North West Rheumatic & Musculoskeletal Disorders Commissioning Network: Outcome and value-based commissioning

Introduction

This was the first meeting of the North West Rheumatic and Musculoskeletal Disorders Commissioning Network. The forum brings together stakeholders from across the health and care system in the region to identify opportunities to improve outcomes for patients with rheumatic and musculoskeletal disorders (RMDs). Hosted by the British Society for Rheumatology (BSR) and facilitated by NHIS Ltd, the meeting was attended by a range of local stakeholders including providers, commissioners, local government, the voluntary sector, industry and academia. The network aims to provide opportunities to exchange knowledge, showcase local innovative models of care, facilitate access to data resources and promote collaboration.

The meeting was chaired by Dr Peter Lanyon, President of the BSR, and facilitated by Paul Midgley, Director of NHS Insight at NHIS Ltd. The meeting involved a series of presentations and facilitated workshops, which have been summarised below.

Welcome from the Chair, Dr Peter Lanyon

Delegates received a welcome and introduction from the Chair, **Dr Peter Lanyon**, who set out the objectives of the meeting, with a focus on service and outcomes gaps for people with living with RMDs and best practice to address these.

Session One: Commissioning for Rheumatic and MSK (Chronic Care) Disorder Services

The first presentation of this session was delivered by **Dr Rachel Gorodkin, Consultant Rheumatologist at the Manchester Royal Infirmary** who summarised the work that has taken place regionally and nationally in relation to peer review, a programme of work led by the BSR intended to encourage quality improvement in local services.

This was followed by **Ms Zoe Ide, Trustee at the National Rheumatoid Arthritis Society**, who discussed her experiences as a person living with Rheumatoid Arthritis and took delegates through what the patient really wants from their rheumatology service. She also underlined the issues revealed in the national audit that are impacting on patients' lives.

The final speakers of this session were **Dr Rikki Abernethy, Consultant Rheumatologist and BSR Regional Chair for Mersey** and **Dr Neil Snowden, Consultant Rheumatologist and Chair of the BSR Inflammatory Arthritis Audit Committee**, who provided delegates with an update on the National Clinical Audit for rheumatoid and early inflammatory arthritis. The first annual report of the audit was published in January 2016 and the second follow-up report published six months later in July 2016. Neil gave an overview of the audit programme development and Rikki provided the regional perspective on the audit findings, outlining how rheumatology units in the North West and Mersey compared with the national average across a number of different measures.

Table discussions on addressing service and outcomes gaps for patients with RMDs

Delegates then broke out into facilitated table discussions to look at service and outcomes gaps for patients with RMDs and how to address these in line with the Five Year Forward View. The following represents the key themes to emerge from these discussions:

- Work is needed to find out why Early Arthritis Clinics are not more widespread. Some debate as to whether having a dedicated clinic is the right approach, as opposed to having ring-fenced slots
- Early Arthritis Clinics must be properly resourced through adequate funding and infrastructure such as admin support and diagnostics. This should not be at expense of follow-up
- There are examples of hospital trusts buddying up with GP networks to improve referrals; this good practice needs to be evaluated and disseminated more widely
- Not enough is known about the factors contributing to referral delays, as it may not be just about symptom awareness, for example GPs may be hindered by IT systems.
- There needs to be programme of awareness raising nationally with GPs on the red flag symptoms of inflammatory arthritis
- This could be supported by protected education slots for GPs and BSR-led webinars to improve primary care awareness
- Awareness raising with the wider public should not be overlooked, as this may encourage patients to engage with the health service a lot sooner. There have been some local campaigns, but also NRAS has reinvigorated its triple “S” campaign
- Peer review needs to be promoted either by making it compulsory or by linking it to financial and/or regulatory incentives
- Underrepresentation of ethnic minorities in audit and other studies needs to be addressed, as rheumatology services may not be meeting the needs of these patients

A panel Q&A then took place which featured Dr Peter Lanyon, Ms Zoe Ide, Dr Rachel Gorodkin, Dr Rikki Abernethy and Dr Neil Snowden. The panel fielded a range of questions from delegates and addressed the points that were fed back following the facilitated discussions.

Session Two: Best Practice Examples for Commissioning for Rheumatic and Musculoskeletal Disorder Services

The Chair, **Dr Peter Lanyon**, then introduced the second session of the day which explored best practice examples for commissioning rheumatic and musculoskeletal disorders.

The first presentation was provided by **Dr Cristina Estrach, Consultant Rheumatologist from the Royal Aintree Hospital**, who outlined the rheumatology service redesign that took place in Aintree, which saw the introduction of a treat to target approach at no additional cost. This redesign led to a 46% rise in people being seen within three months of symptom onset and generated an annual saving of £600k from the reduced use of high-cost biologic drugs. This achievement was recognised in the 2013 BSR Best Practice Awards.

This was followed by **Dr Alison Lea, GP and Clinical Lead for Planned care at Tameside and Glossop CCG**, who provided insight into the development of an integrated care model for rheumatology and MSK services in her locality. Alison set out the health challenges in Tameside and Glossop and the

collaborative effort that has led to implementation of an integrated model of care to help address these challenges for the local population.

Another example of best practice was set out by **Dr Ben Parker, Consultant Rheumatologist at the Manchester Royal Infirmary**, who gave an overview of the development of a virtual biologics clinic at the Manchester Royal Infirmary, which has helped reduce delays in biologics initiation, improved outcomes and increased clinical trial recruitment. Through the introduction of standardised biologics prescribing pathways and multidisciplinary team review of patients initiating biologics, a £113k reduction was generated on the cost of biologics to the CCG in the first 6 months. This initiative was a BSR Best Practice award winner in 2016.

Table discussions on which examples of improved outcomes and value are best suited to meet the local challenges and how can they implemented?

Delegates then broke out into facilitated table discussions to explore examples of improved outcomes and value and how to implement them. The following represents the key themes to emerge from these discussions:

- Work must be carried out to identify GPs with an interest in MSK/rheumatology to be local champions and influence their GP peers. BSR may need to look at supporting this cohort
- Consideration should be given to broadening this group of local champions to others working in primary care such as practice nurses, physios, pharmacists, etc
- Shared care protocols between primary and secondary care on medicines/disease management need to be standardised as there is much variation
- Ultrasound training should be more widespread as there is significant benefit to patients of having this diagnostic procedure as early as possible. Some sites opt for using consultant sonographers
- Technology very much underused to empower patients to self-care and improve exchange of information between patients and healthcare professionals e.g. real time monitoring
- There is a need to spread best practice around biosimilar switching, to ensure better equity of access and outcome across areas
- The identification of “best practice champions” supported by travel fellowships could support the spread best practice
- Professional bodies, patient groups and the pharma industry should work together to produce patient education on treatments and symptom recognition
- Commissioners and service planners need to consider the clinical and cost effectiveness of moving services into the community, as there is doubt on both counts
- Nurses need to be more greatly involved in follow-up, however, they do not have the time to do this as they are running drugs clinics. Workload could be shared across other professions, including the new cohort of physicians’ associates
- To reduce the number of missed appointments for follow-ups, clinics should be better co-ordinated, have protected slots and be available out of hours.

A panel Q&A then followed featuring Dr Peter Lanyon, Dr Cristina Estrach, Dr Alison Lea and Dr Ben Parker, who fielded a range of questions from delegates and addressed the points that were fed back following the facilitated discussions.

Dr Peter Lanyon closed the meeting by providing a summary of the key points to emerge and discussing potential next steps. Peter underlined how this event is part of a series that have taken

place in 2015 and 2016 across many regions of England, including the Midlands, Yorkshire and the North East, London and the South West, with one to be held in the East of England in December. The BSR will explore how to build on this model of regional engagement in 2017.