

BSR Commissioning Development Network meeting

Friday 22nd January 2016, St Bride Foundation, London

1. Introduction

This meeting was organised by the BSR's *External and Engagement Committee* as a follow-up to the Commissioning and the Voluntary Sector Seminar held in September 2013. The meeting involved a series of presentations and facilitated workshops that aimed to provide insight into the main challenges to commissioning and providing services for people with rheumatic and musculoskeletal disorders. The following is a summary of the presentations and workshop discussions.

2. Welcome and introduction

Delegates received a welcome and introduction from **Professor Simon Bowman**, *BSR President*, who outlined the aims of the day and the range of speakers and topics that would be covered, including delegates' experiences of engagement with the commissioning process and different approaches to service development.

3. First session: Rheumatic and musculoskeletal disorders: chronic and complex disease care commissioning in NHS England — state of play

The session chair, **Dr Peter Lanyon**, introduced the first session of the day, which outlined the commissioning environment in which we operate and the range of experiences that clinicians have had in developing services in this environment. He underlined the importance to the specialty of meaningful engagement with commissioners to avoid poor decisions being made on service development.

The first presentation of this session was delivered by **Dr Gavin Clunie**, *Chair of BSR's External and Engagement Committee*, who gave an overview of the NHS England commissioning landscape and the role of rheumatologists delivering musculoskeletal (MSK) and rheumatology services within this. He referred to the aims of the Five Year Forward View for the NHS, which promotes more focus on disease prevention, and for new models of care to be developed that break down traditional barriers to the delivery of care. He highlighted the role that rheumatologists and the rheumatology community, including the BSR, could play in influencing this agenda nationally and in local service configuration.

This was followed by three contrasting perspectives on the commissioning experience. The first of which was provided by **Dr Tim Tait**, Consultant Rheumatologist at Sheffield Teaching Hospitals Trust. He set out the innovative approach taking place in Sheffield, as the Trust moves towards 'outcomes-based' commissioning based on a person's life course. For MSK services this has meant developing new outcomes measures with referrals triaged by consultants and some pathways integrated with primary care-based services.

This was complemented by **Dr Vijay Hajela**, Consultant Rheumatologist at Brighton and Sussex University Hospitals NHS Trust, who outlined his experience of the commissioning process within Brighton and in adjacent rural Sussex. He described the poor engagement between commissioners and rheumatology specialists during the procurement exercise, which resulted in commissioners failing to take into account the number of existing patients in their local needs assessment. He also referred to a high-profile reversal of the award of the MSK contract in coastal Sussex.

A third speaker, **Dr Henry Penn**, Consultant Rheumatologist at Northwick Park Hospital, London, gave an account of the MSK service procurement process across North West London, which aimed to transfer all outpatient rheumatology services into the community over three years. This process was

blighted by factual inaccuracies, lack of engagement between commissioners and providers, poor public consultation and no risk assessment — to the extent that the procurement was abandoned at great cost.

4. Table discussions on what these experiences mean for rheumatology?

The group then broke out into facilitated table discussions to explore what could be learned from these different experiences of the commissioning process. The following represents the key themes to emerge from these discussions:

- A commissioning process appears to work more smoothly when dealing with just one CCG. As more CCGs form into federations, better outcomes from negotiations should be facilitated;
- For existing rheumatology units ('providers') and for new providers wishing to bid for services, having strong financial and clinical data is key to successful negotiation with commissioners;
- It is important to be proactive in engaging with commissioners and not wait until plans have been made. Partnering with patients and other specialties can make the case for maintaining and/or developing integrated rheumatology services stronger;
- Some procurements have failed owing to poor engagement with patients or patient disease/group advocates;
- It's important to ask commissioners for impact assessments to be carried out during procurement processes. Commissioners are required, under 'good governance' practice, to be doing these but this is not always the case;
- There is a problem of language. Rheumatology can be viewed as purely subsumed into musculoskeletal conditions, but rheumatology services would probably benefit from being viewed as a discipline providing care under a 'long-term condition' definition;
- There needs to be more use of the voluntary sector in bids for contracts as many voluntary organisations have a great deal of knowledge and experience to offer clinicians to complement any conventional service configuration provided by statutory providers.

Then another perspective was provided by **Dr Neil Snowden** who spoke about his experience as a consultant rheumatologist with *Pennine MSK*, a primary care-based provider, delivering rheumatology and MSK services across the Oldham area. He emphasised the need for co-location of primary care and specialist clinicians, and diagnostics to ensure better co-ordination of patient care and highlighted the importance of high-quality administrative support as an often overlooked part of the multidisciplinary team.

5. Panel Question and Answer session

A panel question and answer session then took place that featured the above speakers. The panel fielded a range of questions from delegates on their experiences of developing services and engagement with commissioners. The panel discussed:

- the need to support general practice in terms of improving knowledge of conditions and upskilling GPs to deal with more cases. A federated approach to commissioning may help facilitate this;
- the need for a range of rheumatology outcome measures. Current measures are blunt and not always relevant. For example 'new to follow-up' ratio of outpatient visits and in-patient statistics are poor indicators of quality or safe care; Functional and quality of life indicators are relevant but there is a lack of complete disease-specific, validated measures available. The EQ5D is a generally meaningful measure which might feasibly be adopted more universally.

6. Second session: Commissioning chronic and complex rheumatic and musculoskeletal disorders in 2016. Who is/should be involved? Why? How?

The session chair, **Dr Gavin Clunie**, then introduced the second session of the day with four speakers who provided insight into the key elements required to commissioning high-quality services for people with rheumatic and musculoskeletal disorders.

The opening presentation was provided by **Professor Peter Kay**, *National Clinical Director for Musculoskeletal Conditions*, who gave an overview of the value of professional organisations within healthcare, in informing commissioning, both through formal and informal channels. He related how the subtle shift of rheumatological conditions away from MSK conditions, to be viewed as long-term conditions, has helped raise its profile. He suggested that clinicians need to be as proactive as possible with commissioners and be armed with data to help make the case for change. Finally, he emphasised the importance of linking data collection to financial incentives to ensure that trust allocate adequate resources to it.

Jeremy Taylor, *CEO National Voices*, then outlined the role of National Voices as an umbrella organisation for patient organisations and underlined the importance of meaningful patient input into service and commissioning decisions.

This was followed by **Laura Guest**, *BSR CEO* who added insight on managing data to support the development of rheumatology services and gave an overview of the range of programmes of work that the BSR is embarking on, generating data on a range of issues in rheumatology including compiling disease registers, audit, developing a standardised core data set for rheumatology service 'outcomes' and facilitating the linking of the clinical data to other national databases.

Dr Neil Snowden, *Chair of the BSR Clinical Affairs Committee*, then spoke about the newly published first annual report of the National Rheumatoid and Early Inflammatory Arthritis (EIA) Audit. He outlined key findings of the audit and its important role as a repository of data to inform service improvement. The main findings were that:

- only one in six EIA patients were referred by their GP to rheumatology services within three days, (NICE Quality Standard 33 [standards for rheumatoid arthritis management], statement 1); with a quarter waiting more than three months to be referred;
- 38% of EIA patients were seen by rheumatology services within three weeks of referral (NICE Quality Standard 33, statement 2);
- just over half (53%) of EIA patients were started on disease modifying antirheumatic drugs (DMARDs) within six weeks of referral (NICE Quality Standard 33, statement 3);
- longer waiting times for appointments were associated with lower levels of consultant numbers (in the relevant rheumatology departments), whereas departments that had early inflammatory arthritis clinics had significantly shorter appointment waiting times.

7. Workshop session

The session chair, **Dr Gavin Clunie**, introduced the final session of the day, in which delegates then broke out into facilitated table discussions to explore four different issues in relation to developing services. Below is a synopsis of these discussions:

Question 1 — What are the main priorities for linking service pathways horizontally (either within Primary Care or within Secondary Care systems) and vertically (across Primary and Secondary Care) for general and rare diseases — list the services involved?

There was a consensus that the main priorities were to provide higher quality care by services being better co-ordinated around the patient and not around organisations, and to optimise the use of finances and resources, including staff.

The group outlined a 'network of networks' approach with the patient at the centre with links across primary, secondary and voluntary sectors. The focus would be on whole person needs with access to a range of services including psychological support, nutrition, pain management, pharmacy, etc. The network would be underpinned by well-defined pathways and codes to fast-track referrals to rheumatology and would involve upskilling of all healthcare professionals including first contact professionals such as paramedical staff, GPs and pharmacists.

Question 2 — *What are the benefits and disadvantages of integrating MSK, rheumatology and pain management?*

The group first recognised that currently services are integrated in some areas but practice was patchy. Delegates then outlined the following benefits and disadvantages of this integrated approach, which are summarised below:

Benefits

- better co-ordinated care with patients able to access the right services in a timely manner;
- robust triage with clear protocols and lines of communication. This would involve a single point of access that does not require return back to the GP for referral;
- improved collaboration between specialists, fostering opportunities for cross specialty training and collaborative research;
- more cost-effective and efficient in the longer run.

Disadvantages

- a risk that rheumatology will always lose out against better defined specialties such as orthopaedics and that all services will be assessed using the same set of blunt and inappropriate measures;
- drugs will usually be more expensive than surgery, in the short term, making the business case difficult to put to commissioners for rheumatology services;
- difficulties for patients in terms of providing all aspects of the services out-of-hours.
- challenges regarding the management of complex patients within integrated services and the interface with specialised commissioning.

Question 3 — *How do we ensure the people with the right knowledge and skills provide input at the appropriate time?*

The following points emerged from the group discussions:

- the multidisciplinary team (MDT) approach is an accepted mode of care delivery, embedded within rheumatology, however, more needs to be done to adapt MDTs to cover the crucial interface between secondary and primary care;
- obtaining the MRCP to qualify for specialty training in rheumatology is currently not an option but might be an option worth exploring with RCP and the Rheumatology SAC so as to improve training in integrated patient pathways across Primary and Secondary Care in rheumatology practice. It was noted that MRCP qualification for specialty training already exists in other specialties such as sports and exercise medicine;
- opportunities to improve knowledge of GPs need to be fostered and given proper resources, not merely relying on the goodwill of a few individuals;

- standardised pathways and protocols for disease management (e.g. early inflammatory arthritis) should help to ensure the appropriate deployment of skilled staff. This includes establishing triage, which should be led by senior clinicians;
- investment is of great importance both in terms of staff recruitment and retention and in terms of ensuring there are robust financial, administrative and governance systems to support the agreed integrated system of care;
- fostering local leadership with support from BSR and local patient organisations should be the norm when invoking change in service configuration so that there is an overview of all aspects of service including pathways, workforce numbers and skills and training.

Question 4 — What principles in our service should we promote to advocate and facilitate resources to be used efficiently?

The main principles to come out of the group discussions were:

- the right service for the right patient. This means looking at the person as a whole and considering the full range of services and support they might need and where the priority lies for them e.g. support to return to work;
- timely triage — clinically led and informed;
- collaboration across specialities and with primary care. This collaboration will provide opportunities for closer working, personnel education and support of colleagues;
- decisions on service configuration should be evidence-based, drawing on guidelines and quality standards, and founded on sound economic evaluation of cost-effectivity;
- rationalising the use of investigations and sharing diagnostic information across the MDT. Co-location facilitates this process;
- early diagnosis and intervention to avoid diseases worsening to cause permanent morbidity, early mortality and increasing costs to NHS in the long-term;
- efficient medicines management e.g. sub-cutaneous methotrexate. The entry of biosimilars into the market will change the (use of/cost of) medicines landscape;
- investing in patients as an education resource for other patients and healthcare professionals;
- investing in education for patients and supported patient self-management programmes;
- the use of national and other data (e.g. the national EIA audit data) to expose and inform about gaps in care pathways from a lack of resources (e.g. bureaucracy-related delay from some, but not other, referral management systems).

Future meetings

Attendees were informed of a series of commissioning events across BSR regions, with meetings planned for 2016 in Yorkshire, Humber & the North East; London; South West and East of England. This includes a second meeting of the Midlands Rheumatology and Musculoskeletal Commissioning Network, following on from the first meeting held in November 2015.