Age Cymru consultation response – Arthritis and Musculoskeletal conditions in adults

1. **In light of the effect of the pandemic on service, what should musculoskeletal services consider?**

Statistics for April 2021 show that of the 223,365 waiting nine months or more, 87,918 are for trauma and orthopaedics[1]. There has been an increase of 712% in patients waiting more than 36 weeks to start hospital treatment between January 2020 and early 2021[2]. The risks of musculoskeletal conditions rise in most age categories: 51.4% of those aged 55-64; 58.9% for those aged 65-74; and to 62.8% for those aged 75-84.[3] Older people have told us of the extreme difficulties they and their loved ones are experiencing as a result of increasing waiting times.

Our recent report on older people's experiences of the most recent lockdown highlights issues that older people and their carers are facing with delays in hospital treatment.[4] The majority of conditions that were identifiable through responses were for musculoskeletal conditions. Older people have told of the stress of waiting and not knowing when treatment is going to start. They told us of how they are unable to sleep due to pain, some have been forced to access private services rather than wait for NHS services to reopen and others spoke of their reduced mobility and worsening mental and physical health because of the long treatment waiting times.

This is backed up by information from Versus Arthritis that highlights that the pausing of elective orthopaedic services during the pandemic has resulted in many people with arthritis and musculoskeletal conditions waiting significantly longer for life-changing procedures such as joint replacements. Discussions with partner charities have highlighted cases where some people are waiting up to 4 years for a hip replacement.

Many people awaiting treatment will have significantly poorer quality of life, some will be unable to work, some will be unable to provide childcare for their families and some will be at risk of losing employment whilst waiting for treatment. Increasing waiting times will have a huge effect on the wider Welsh economy. It is therefore vital that the Welsh NHS prioritises rebuilding capacity for elective surgery immediately.

[1] https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/wales-waiting-times-april/
[2] https://www.rcseng.ac.uk/about-the-rcs/government-relations-and-consultation/position-statements-and-reports/action-plan-for-wales/

[3] Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2019 (GBD 2019) Results. Institute for Health Metrics and Evaluation (IHME), Seattle, 2020
[4] https://www.ageuk.org.uk/globalassets/age-cymru/documents/covid-19-survey/covid-survey-report---english-final.pdf

This needs to be upscaled from pre-pandemic levels as waiting lists were already growing. It is also vital to consider developing additional wrap around support for those currently waiting for treatment to overcome some of the negative effects of delays and assist with preventing more serious interventions.

2. **What digital solutions are required to support clinicians undertaking their role?**

Though improvements are being made, the Welsh NHS would benefit from increasing the integration of client record, case management systems, diagnosis and referral systems, and care pathways. This reduces inappropriate referrals, reduces duplication across disciplines, and reduces human errors in transfer of information from one system to another (particularly when staff face high workloads). The time gained from this frees up clinicians to treat more patients, and so assists in reducing waiting lists. Time gained can also be used to monitor and evaluate system improvements and so contribute to further improvements in patient experience. An example of where this has worked well was in Canterbury, New Zealand with the development of HealthPathways, an electronic request management system and a patient information website. HealthPathways is essentially agreements on best practice that are created by bringing together hospital doctors and GPs to decide what patient pathways should be for specific conditions. They detail what treatments can be managed in the community, what tests are needed before a hospital referral and where GPs can access resources. This system was introduced as part of wider changes that successfully managed to bring waiting lists down.[5] Such a holistic system could be useful in the creating of a care pathways and a treatment framework for MSK conditions.

At the point where patients require digital skills to aid their recovery, careful consideration needs to be given on whether this is possible for all. Some older people in Wales are not able to access online information and some that lack the skills for using digital technology. In Wales 52% of people over 75 do not have broadband access and many older people do not use computers and smart phones.[6] It is important that older people who are unable to use digital technology do not become digitally excluded from treatment.

Our recent survey on older experiences of the most recent lockdown has highlighted a range of views from our respondents regarding the use of digital technology.[7] This survey was a repeat of an earlier survey undertaken during the first lockdown of the CV19 pandemic. Many respondents to our first survey (August to September 2020) told us that they struggled with changes to the usual ways of accessing primary care

[5] Timmins N & Ham C (2013) The quest for integrated health and social care A case study in Canterbury, New Zealand The King's Fund The quest for integrated health and social care: A case study in Canterbury, New Zealand (kingsfund.org.uk)
[6] National Survey for Wales, 2018-19: Internet use and digital skills (gov.wales)
[7] https://www.ageuk.org.uk/globalassets/age-cymru/documents/covid-19-survey/covid-survey-report---english-final.pdf

and that as a result they were not getting access to the treatment they needed. There was an increase in respondents to our second survey (March and April 2021) that were adapting to newer ways of accessing care and seeing waiting times reduce because of the changes and some felt that this was an improvement. However, some respondents told us of experiences of misdiagnosis through online appointments. Some told us of increased use of emergency services because they could not access care when they needed it. Some explained how they do not feel comfortable without face-to-face appointments as they need to see the person who they are trusting with their health; for some digital technology is a barrier to patient engagement and so patients need to be able to access treatment in ways that are important to them.

Changes to traditional forms of patient interaction that have happened through necessity through the pandemic should be looked at to evaluate which areas have proved beneficial and which have not. Areas that have helped reduce waiting times and benefitted the patient should be considered for continuation as part of the development of the framework.

3. **What extra provision is needed to support those on waiting lists or receiving management and support in primary care?**

We welcome the framework's inclusion of this important area, particularly with increased waiting lists seen through the pandemic. Whilst any wait for treatment needs to be reduced and eradicated in the long term, it is vitally important that a concerted effort to provide support to people on waiting lists is made to reduce a further loss of physical and mental health for the pandemic recovery phase. Our recent survey on older experiences of the most recent lockdown has highlighted an increase in feelings of loneliness and isolation in older people in the most recent lockdown and there is a significant proportion of those older people who told us of reduced health and an inability to exercise safely.[8] It would be helpful if people on waiting lists for treatment were signposted to community groups and physical activity groups who can assist with reducing loneliness though safe activities relevant to their expected diagnosis, as well as groups that can assist with pain management, healthy eating and overcoming addictions.

Signposting should not be just via online means as many older people are digitally excluded. Leaflets needs to be available for those that do not have access to the internet that include contact details for befriending services. Information on healthy eating, weight loss and smoking cessation should be offered at the same time. One action in the framework is to embed First Contact Practitioners into primary care. If FCPs are an early priority for action, monitoring activity in this area will assist with identifying highest areas of need and which other actions require increased prioritization.

[8] https://www.ageuk.org.uk/globalassets/age-cymru/documents/covid-19-survey/covid-survey-report---english-final.pdf

4. **Does the introduction identify the key issues relating to the conditions and services throughout Wales?**

Yes. Information contained in the introductory section sets out the scale of musculoskeletal conditions, the main contributing factors to the various conditions. With an ageing population and rising levels of obesity and physical inactivity, prevalence is set to rise. It is therefore also likely that co-occurring conditions will also increase.

As the number increases, so too will the number of carers for people with MSK conditions and consideration for training for carers should be considered as part of the wider care pathway. This would allow carers to understand the condition better and so be able to provide the right support to the person they care for. Social prescribing as part of the care pathway should include information and advice for carers.

5. **Are the proposed actions appropriate and will they provide the service required?**

The actions included are appropriate when read with the entirety of the consultation document which provides further detail. It is unclear what is expected in cases where the range of services through social prescribing, for example, is not available. We have seen the erosion over time of the availability of community activities for a variety of reasons. It is unclear from the document where responsibility lies for resourcing activities in places where they do not currently exist.

Clarification would be helpful in some areas to ensure that the aims of the actions do not result in a tick box exercise and further detail is required on where primary responsibility lies. For example, health boards are required to ensure that there is access to programmes for physical activity, but the range of programmes currently available is not included within this consultation so it is unclear whether additional work is required to develop the range of support and treatment options for patients.

Health boards will need to decide the most effective ways of meeting the aims of the framework and it would be helpful to have a timeline for implementation to ensure that proposed changes happen in a timely fashion. For example, the development of accessible surgery hubs across Wales would reduce waiting times and allow patients to access the services and support they need closer to home. This in turn would assist with reducing waiting lists and recovery time.

It would also be helpful to have a timeline for implementation and how actions will be prioritized.

Prevention, self-management and independence

6. **Does the guidance demonstrate the most effective and efficient approaches to develop self-management skills and maximise independence?**

Primary prevention is not fully covered in this consultation document. Whilst a great deal of information is provided in terms of how some conditions can be prevented, actions expected through the consultation focus on pre-treatment onwards.

For example, it is good practice to offer tests for osteoporosis following a fragility fracture. By the time a fracture occurs, bone density is already compromised and the risk of further fracture is already higher. (For clinical services we recognize that this is of course their earliest opportunity to provide an intervention.) Health promotion programmes already exist and will assist in the longer term with reducing the volume of people developing MSK conditions. However, it is unclear how wide-reaching health promotion programmes are, and it is likely that many people at increased risk of MSK conditions are either not being reached or have not fully understood the implications for their future health and well-being. It is therefore important that health promotion programmes are targeted at specific groups of people and geographical locations where there is increased risk of the development of MSK conditions (e.g., socio-deprived areas).

There is a need to consider in prioritising actions from this framework how long people have been waiting for treatment and how this affects both their physical and mental health, as well as their life circumstances such as employment. It is likely that the demand for support for self-management outstrips supply. How this is managed requires further careful consideration by health boards and wider support groups.

The model for access and condition management of adult long-term musculoskeletal conditions, excluding osteoporosis

7. **Does the chapter provide a clear and comprehensive model for healthcare professionals to follow? Are there any further changes required to this model?**

This chapter sets out what is required from health care professionals and details the stages of treatment.

The flow chart included on page 28 of the document suggests a single direction of travel for all musculoskeletal conditions from pre-diagnosis through to rehabilitation. As previously stated, older people are at increased likelihood of experiencing multiple conditions and so consideration needs to be given on how people with more than one condition can access the services they need at the right time and in the right place within this flow chart. There will also be numerous cases where patients have been through the care pathway, or partially through the care pathway, but due to a change in condition/circumstances they need to access services differently. This

is referenced in the consultation document but not in the flow chart and should be considered.

Diagnosis, treatment and long-term management of osteoporosis and fracture risk in adults (aged 18 and over)

8. **Does the guidance capture all the elements of managing and limiting the impact of Osteoporosis?**

The guidance outlines those who are at risk of osteoporosis well and we welcome the recognition of the variations in risk for older men and women. It includes all areas that we are aware of to manage and limit impact of the condition. It would be helpful to include best practice referral, assessment and treatment times in the fracture prevention pathway diagram to assist Health Boards work towards reduced waiting list times.

Workforce development, education and recruitment

9. **How can this chapter be strengthened to address workforce education and recruitment?**

Health care staff should be provided with wider training to assist with a more holistic treatment approach to help improve patient outcomes. Particularly for working with older people, it is important that staff have received human rights, dignified care and dementia training. This should include respectful communication, protecting privacy, promoting autonomy and addressing essential needs such as nutrition, hydration and personal hygiene in a sensitive manner. We are aware of older people who have struggled to communicate with health staff in hospitals through hearing, sight and memory impairments. It is therefore vital that staff are aware of these additional needs to ensure patients are fully informed and involved in their treatment.

10. **How can we ensure health and social care professionals are aware of how to treat and manage musculoskeletal conditions effectively?**

Health and social care staff and providers must be trained on equality and diversity issues to ensure that the needs of all vulnerable groups are met appropriately. They should receive training detailed in (11) above.

Additional questions

11. **What third sector provision and support can be utilised to support this area?**

The consultation document references social prescribing, which is one area where the third sector are able to provide a great deal of support to complement health service treatment. Elsewhere within this response we refer to befriending services and community interest groups to assist with loneliness and isolation and reduce the negative impacts on mental health. Third sector organisations provide added value in that they often have increased flexibility over public services to provide very tailored support based on what the person needs.

12. **Certain conditions are known to disproportionally affect people with particular characteristics, such as gender or race. Are there any further considerations required to address any inequity of treatment?**

The framework includes some reference to increasing needs with age but this should be clearer in some areas. The majority of patients with musculoskeletal conditions are over 40 and numbers rise with age. Some conditions are more pronounced in older people and older people are more likely to suffer from multiple conditions. As such it is important that age related factors are considered in prevention, diagnosis and treatment.

13. **We would like to know your views on the effects this guidance would have on the Welsh language, specifically on opportunities for people to use Welsh and on treating the Welsh language no less favourably than English.**

    What effects do you think there would be? How could positive effects be increased, or negative effects be mitigated?

It is important that people with musculoskeletal conditions can access health and wider services, including social prescribing, through the language they are most comfortable communicating through. This is especially important for older people with co-occurring conditions such as dementia and other memory related conditions. When in pain and under stress, a first language Welsh speaker may not be able to understand and retain information in languages other than Welsh. As such it is important that there are Welsh speaking staff in each area of service that the patient needs to access and that a stable Welsh speaking staff base provide care and treatment to people with dementia related conditions.

14. **We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:**

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Age Cymru welcomes the development of this draft framework to improve patient outcomes. If fully implemented, this will benefit many older people in Wales, both now and in the future.

A great deal of information is included within this framework and many wide-ranging actions are required to achieve these aims. It would be useful to understand the level of additional resource that will be available in which area of the treatment pathway to achieve improved outcomes for patients. We are aware that Welsh Government have provided additional funding to support NHS recovery from the pandemic, but not how much of the additional funding will be directed to support the various elements of MSK service recovery.

Further, improved outcomes for patients will require the availability of wider support to overcome the damaging effects on both physical and mental health of long waiting times so it is important that pre-habilitation support is made available early. It is likely that the volume of pre-habilitation support is insufficient to meet demand and so consideration needs to be given on how that demand can be managed and met.

We would also welcome additional detail on timescales for the actions within the Framework, clarifying the most urgent priorities. We understand that this framework was drafted pre-pandemic and that the volume of work may not be fully understood at present. We are aware that many pre—pandemic some people did not have a full diagnosis of their MSK condition and that many were already waiting for surgery. Without diagnosis, treatment and recovery are delayed and without surgery many older people's physical and mental health has deteriorated. It is therefore vitally important that diagnosis and addressing the surgical waiting times require a very early focus.

We are also aware that treatment methods have changed over the years and that some older people with MSK conditions for many reasons may have not had updated advice on medication, the importance of safe exercise and healthy eating that would benefit them. It is therefore important that the framework includes the necessity to review existing patient care to ensure that this is up to date.