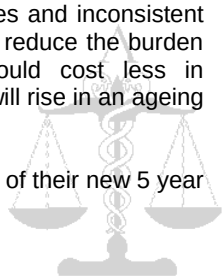
Department of Health June 2006
The Musculoskeletal Services Framework

The department of health provides for the formation of multidisciplinary teams to manage musculoskeletal disorders. Coordination of rehabilitative efforts seems to have been left to chance; leaving an opportunity for private case managers to exploit.

Service frameworks are developed in response to inconsistent availability of services and inconsistent service offerings across England and Wales. Accurate and available services could reduce the burden of morbidity associated with musculoskeletal disorders. Healthier workers would cost less in compensation. 30% of GP consultations are about musculoskeletal complaints; this will rise in an ageing population.



It is expected that the EC will confirm concern over musculoskeletal disorders as part of their new 5 year strategy for occupational safety and health.

Essentially the framework is:

- Patient decides whether or not to seek medical help. The framework proposes to provide substantial off line information to the general population in order that the decision to consult will be well informed and appropriate.

- GP decides whether or not to attempt to manage the situation in-house. The option being referral to Musculoskeletal clinics. The framework offers to recommend active management, supported self-management, patient guidance and access to less intensive services such as podiatry.

- Musculoskeletal clinics would be the first port of call for referred patients. These would contain a broad team of medics, complementary services, psychologists etc. and would refine any diagnosis and patient information. Musculoskeletal clinics are a new idea in many areas of England and Wales. Of particular note is the commitment to full biopsychosocial assessment at the first opportunity following referral. Rather disappointing then to find that there is no mechanism specified for the delivery of biopsychosocial interventions unless they happen to involve some sort of medical service. Occupational therapists are probably best placed to oversee rehabilitation from a medical point of view but are unlikely to have much influence over employers or social services unless their role is formally specified in national policy. They will be available by referral from the Musculoskeletal clinic.

- Hospital services such as rheumatology, pain management clinics, occupational therapy and orthopaedics.

Each of the above is in principle explicitly linked with back to work vocational reintegration for those at work or of 'working age'. The mechanism for this non-medical service is in our view a critical facet of any musculoskeletal service. There is no specific facility for this mentioned in the policy document other than that GPs should develop working relationships with the local "Pathways to Work" pilot programmes offered by DWP. The Department of Health promises to research further into what might work and how to provide it.

The framework makes the following notable assertions:

- Both absence of and an excess of stress on the joints can increase the risk of osteoarthritis.

- Obesity is likely to increase the pain felt by those with osteoarthritis especially in the hips and the knees.

- It has been estimated that in 2001/02 over 1 million people in Great Britain had a musculoskeletal condition caused – or made worse – by their current or previous job. An estimated 12.3 million working days are lost every year through work-related musculoskeletal problems.

- Certain occupations carry a high risk of osteoarthritis: farmers and agricultural labourers are much more likely to develop osteoarthritis of the hips while professional footballers are especially prone to osteoarthritis of the knee.

Comment
The Framework offers an opportunity to streamline the multidisciplinary approach that is often needed when dealing with musculoskeletal complaints. The aim is to get to the bottom of a case within 18 weeks. Improved coordination and delivery should lead to reduced work absence in those who have

been injured but only if the reason for continued work absence is some medical effect of the injury event. Those who need non-medical help will not get it from this service.

Non medical effects will be identified by biopsychosocial assessments and these should be made very early on in the case. The system makes only limited provision for biopsychosocial interventions.

The Framework identifies a lack of organised provision of rehabilitation services and interventions. This provides an opportunity for the private sector to step in. Where the disorder is work-related this could involve a liability insurer.

The majority of patients are able to return to work after medical interventions have ended but around 15% to 20% are delayed by non medical factors. Identifying these and dealing with them early on should reduce the burden on private insurance; if left to their own devices these cases are disproportionately expensive.