

CROSS PARTY GROUP ON ARTHRITIS AND MUSCULOSKELETAL CONDITIONS

MINUTES OF MEETING ON 5 DECEMBER 2012

Introduction

1. Helen Eadie welcomed those present, in particular the speakers, Niamh Hegarty of Morhamburn and Dr Phil Mackie, Lead Clinician of ScotPHN.

Meeting on 24 October

2. The minutes were proposed by Iain Macdonald and seconded by Kate Wright.

3. Dr John Hunter of SSR had suggested, in light of the SG replies to Helen Eadie's Parliamentary Questions on RA, a further be asked on what responses the SG had had from Health Boards on the ScotPHN Report and what action they plan on the basis of its recommendations. A concern was expressed in the meeting that statistics asked for in a number of the Questions were not held centrally: these figures might be important for better-informed decision-making.

SIDRIG: Findings of Recent Work by Morhamburn Updating Report of 2008 on Delivery of RA Services in Scotland

4. Diane Thomson apologised to members on behalf of SIDRIG that, due to changes in the rules for approval and compliance within ABPI therapy groups and the need to adhere to the Code of Practice, it had not in fact been possible to sign off the Report. At this stage it would be appropriate only to share the draft: Niamh Hegarty of Morhamburn, who had been commissioned by SIDRIG to undertake the survey, would do this. Once approval had been arrived at, the Group would return to the Report for a full presentation and discussion, at which point it could decide how best to take things forward.

5. The Report, *Delivery of RA Services in Scotland: View of Healthcare Professionals*, was the product of an updating exercise, looking at emerging trends since the work done for SIDRIG in 2008. Main themes were early diagnosis, intervention, service provision, auditing of services and SIGN Guideline 123 on the Management of Early RA. The main draft recommendations pointed to the need for: greater recognition of RA issues; adequate steps in raising staff awareness; better exploiting the opportunities to share excellent examples of best practice; supporting and promoting RA care via the Long-Term Conditions Priority List; questions on Health Boards' recording and monitoring of RA services; Health Boards to fulfil their duty to action Guidelines.

6. The following draft points were made in discussion:

1. It was regrettable that RA, one of the original markers on the Long-Term Conditions Priorities List, had failed to receive the intended additional attention and support.
2. Results appeared to show a worryingly low percentage of patients with access to an MDT.
3. There were signs of variation over Board areas in nurse-specialist provision and possibly resource pressure to deploy nurses away from long-term conditions to acute care.
4. Taking a view about the budget for RA was problematic as it was embedded in wider spending.

ScotPHN Report, Health Care Needs Assessment for Services for Adults with RA

7. Dr Phil Mackie outlined the background to the Report, the role of ScotPHN and the policy and evidence context, emphasising that these two now coincided, offering a genuine opportunity for progress in delivery of RA services. Key findings covered the need to shift practice towards early diagnosis and treatment, appropriate management of chronic disease, access to the multidisciplinary team (MDT), managing cost pressures of drug prescribing, reducing work disability, meeting training and staffing needs and auditing and improving outcomes. These findings sat well with SG priorities: the Quality Strategy, supporting those with long term conditions, promoting continuing employability and reduction in inequalities. In addition, the period since the 2002 report had seen an increased challenge, in terms of demographic factors, to provision of services and care but also huge advances in available therapies. Health boards would feedback to ScotPHN on the Report early in 2013 with the formal SG response thereafter. There were early indications of the view in government that this was an effective invest-to-save area, and of an appetite to push forward the agenda.

8. Discussion and questions covered the following:

1. In responding to the Report Health Boards would achieve most by looking at the pattern of their priorities and working with the grain of existing provision, thus making possible consolidation and marginal change without an increase in budget.
2. A variety of different models might be appropriate, for example the MCN in Glasgow, the peripatetic service in Fife, arrangements appropriate to the needs of remote areas.
3. Early diagnosis was critical: although improvement was always possible, there was encouraging evidence of this message getting across; mass screening of the wider population was not practicable, there being no simple test available.

4. It was essential to strike the right balance between early diagnosis/treatment and optimum management of established disease: the majority of people with RA were, of course, in the latter category.
 5. There should be the appetite to look in a more holistic way at funding policies for biologic drugs, given the very significant savings to the public purse of treatment which keeps people in work: silo budgets did not allow for a true reckoning which offset the benefit against the cost of using these medicines. The difficulty of gaining recognition for this view was at the level of political will: in public expenditure terms fixed costs (for example, salaries of doctors/nurses) would have to be met in a 'double run' with increased drug costs, with savings accruing in the future.
 6. Wider arthritic conditions had a major social impact as well as RA: might the study be extended? The problem with expansion of the field of study was that it would then have no natural limits: the focused approach employed offered a set of tools which could then be used locally for a wide range of conditions.
 7. Much work had been done on quantifying problems, analysing need: how could we measure success in meeting the need? The RA community tended to focus on targets, for example, that for 90% in remission within a year of diagnosis: further hard indicators like numbers of in-patient beds were helpful. The Health Care Needs Assessment tended to set out milestones of progress which could be used locally rather than address measurement of success: the Report's level of clarity could be built into local efficiency.
 8. Outcomes were not just clinical and objective; the patient viewpoint on success was vital to any reckoning. There were some weaknesses in measuring patient information and using it as evidence: standardisation was needed in the use of Patient-Reported Outcomes, the patient view could be affected by a whole range of expectations and might be influenced by experience of the healthcare received. While recognising that patient expectations might shift with the possible, the aim should be to ask patients what they expect and aim for that, rather than for strictly quantifiable outcomes.
- 9.** The ScotPHN Report was a very valuable piece of work: the Group would reflect how it might proceed in order to contribute to progress. We would take note of the SG response in due course.
- 10.** Helen Eadie thanked the speakers for excellent presentations, SIDRIG for the welcome refreshments and commended all concerned for the work they did to bring progress in the field of arthritis and musculoskeletal conditions.
- 11.** The next meeting, jointly with the Cross Party Group on Chronic Pain, would be on 13th March 2013. The AGM of this Group would be held at the start of the meeting.

ATTENDING

Helen	Eadie	MSP
Nanette	Milne	MSP
Guy	Armstrong	UCB Pharma Ltd
Philip	Atkinson	
Julia	Burdge	National Rheumatoid Arthritis Society
Sharon	Campbell	BMI Ross Hall Hospital
Ann	Conacher	Scottish Public Health Network
Diane	Crake	NHS Tayside
Tom	Downie	National Ankylosing Spondylitis Society
Niamh	Hegarty	Morhamburn Ltd
Colin	Howie	NHS Lothian
Janice	Johnson	PSALV
Alan	MacDonald	The Scottish Society for Rheumatology
Iain	Macdonald	National Rheumatoid Arthritis Society
Sheila	MacLeod	National Rheumatoid Arthritis Society
Phil	Mackie	Scottish Public Health Network
Julia	MacKinnon	National Rheumatoid Arthritis Society
Katie	McAlarey	NHS Greater Clyde and Glasgow
Steve	McBride	ARMA Scotland/ Arthritis Care
Elizabeth	Murphy	NHS Lanarkshire
Michael	New	National Rheumatoid Arthritis Society
Diane	Thomson	Pfizer
Richard	Walker	ABPI
Kate	Wright	NHS Forth Valley

APOLOGIES

Catherine	Stihler	MEP
Annabelle	Ewing	MSP
Matt	Barclay	Community Pharmacy Scotland
Carole	Callaghan	Edinburgh Western General
Sharon	Douglas	Scottish Network for Arthritis in Children
Margaret	Duncan	NHS Ayrshire and Arran
Margaret- Mary	Gordon	Greater Glasgow and Clyde
John	Hunter	Scottish Society for Rheumatology
Irene	Logan	Fibromyalgia Friends Scotland
	Lloyd-	Chartered Society of Physiotherapy
Kenryck	Jones	Scotland
Sophie	Matthew	National Ankylosing Spondylitis Society
Anne	Murray	Framework for Adult Rehabilitation

Bea	Nicholson	PMR-GCA Scotland
Patricia	Osborne	Brittle Bone Society
Paulo	Quadros	Intlife Pain
Martin	Perry	Royal Alexandra Hospital
Tracy	Rendall	Scottish Network for Arthritis in Children
Anne	Simpson	National Osteoporosis Society