Quality in private musculoskeletal care: Resource pack

October 2018

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Purpose

1. To profile and benchmark the quality and effectiveness of musculoskeletal interventions in private practice and promote its strengths compared with alternative offerings.

2. To promote growth in the private MSK market using this evidence base.

3. To improve the quality of clinical care and outcomes that matter most for patients.

Background

As consumers in general we increasingly expect evidence about the quality of the products and services we buy.

Such evidence for the quality of private healthcare is becoming available for inpatient and day surgery care, but not for outpatient MSK.

This may be one reason why the broader MSK market isn't growing.

We want to do something about this: to show which types of healthcare are most effective for different types of patients and at which stage during the patient journey.

Currently there are no overall, cross-sector and agreed quality standards for outcomes in private MSK. We know there is wide variation in clinical practice and outcomes and we have no way of benchmarking it.

Providers and commissioners, including insurers, all want to demonstrate value and return on investment, moving away from cost as the main factor to differentiate services, and not to have to rely on fact-free assertions but on a robust evidence base.

Together with clinicians and professional bodies, we all want this information for a range of uses and have an interest in demonstrating the value of private MSK services.

We recognise that there will be several steps to reach the point where we are able to define and evidence quality, given the current status.

Stage 0 of implementation – Current status

Stage 0	Result	Tangible impact
Currently some private outpatient MSK providers collect quality data, whilst many others do not. Those who do use a wide variety of different measures and systems; some using paper processes, others electronically. Each has their own preferences, and some have invested in these approaches over many years. What might be efficient for a large hospital may be impractical for a sole practitioner, particularly from a cost perspective.	Insurers don't use quality data at all and so the only conversations between providers and insurers focus on costs and volumes, plus any complaints which may have occurred. Any providers which consider themselves as delivering a superior quality of care or effectiveness have no tangible evidence to justify these claims.	Patients have no common framework to determine the relative quality of a provider, other than by word of mouth. Choice is influenced by price, convenience, the services offered and branding. There's no reward for providers for investing in better techniques or facilities other than the hope to attract more customers: insurers typically reward them all in a similar manner. The market is stagnant, with no significant differentiation between providers.

Stage 1 of implementation – Data collection

Stage 1	Result	Tangible impact
All providers are invited to collect quality measures based on a common framework, and to invite all of their private outpatient MSK patients to participate. Whilst the categories (e.g. patient satisfaction, patient-reported outcome measures) are the same, the specific measures may be different. Similarly providers may use different diagnostic systems.	Once the patient information has been anonymised, a sample of the collated dataset will enable us to see which measures and systems are more or less useful and insightful. It can also tell us about what's better or less effective in practice, plus participation rates and the actual quality of the data generated. It gives us an evidence base for a debate rather than organisational bias on what the dataset and format should be to facilitate standardisation and comparison. This is an unsatisfactory transitional step because of the lack of proper comparability – we do not as yet have any mandate – but it does provide a shared evidence base to determine what may work for the whole sector, or for discrete segments within it.	Participation gives everyone a stake in the long-term outcome. By showing us who's collecting data and who's not, insurers may choose to prioritise providers which participate over those which don't. When sufficient data has been collected an invitation should be made to organisations which might be able to analyse and report on a standardised dataset at a national level. We will have to agree which organisation is most suitable to report and analyse the data, its outputs plus how this will be funded with the costs shared across the sector, or otherwise. Liaison with professional bodies will be needed to support a mandate for the recommendations.

Stage 2 of implementation – Standardised measures

Stage 2	Result	Tangible impact
Based on the findings of the previous step, specific and defined measures are recommended to all providers of private outpatient MSK.	Consistency of measures and sufficient scale of collection enables us to start to define what impact each type of intervention should have over a time-frame, for a given type of patient with a condition relevant to outpatient MSK.	The reporting organisation starts to propose recommended quality standards, initially at an overall provider level, body-part level and potentially intervention level.

Stage 3 of implementation – Quality benchmarking

Stage 3	Result	Tangible impact
The measures, clinical coding systems and data collection are now mandated to all providers of private MSK.	Case-mix adjustment is now possible because there is sufficient data to enable it. This means like can be compared with like. Patients, clinicians and commissioners have specific and measurable expectations about treatment effectiveness and quality standards. It's now possible to determine expectations of the quality or impact of each treatment, given any diagnosis, because there is sufficient data. Quality rises because of this evidence base for effectiveness and impact which clinicians can reflect upon.	Providers can start to market themselves based on comparative quality. Insurers may choose to make it a contractual requirement for their MSK providers to collect sufficient amounts of quality data. Insurers may start to reward organisations meeting minimum quality standards. These thresholds of quality will have to start at a low level, but build up over time as greater accuracy and validity is generated. This may also impact how insurers approve different types of MSK intervention.

Scope and definitions

Our scope covers all relevant outpatient MSK activity, patient conditions and treatments across the pathway including (but not limited to) physiotherapy, osteopathy, chiropractic and podiatry, soft tissue therapy, sports medicine and CBT.

We also consider how outpatient treatments link to surgical MSK interventions, recognising that patients may transit to inpatient care.

In terms of treatment this could include anything from an single intervention to a package of care, such as a programme of physiotherapy care.

We have considered the perspectives of patients, clinicians and their organisations, insurers and professional bodies across this whole piece of work.

By practitioners we mean all healthcare professionals, from fully-qualified clinicians to weekend course attendees.

Approach

Our collective approach has been led by over a dozen representatives across the private sector, composed of small and large scale providers, insurers and professional bodies, and across different areas of clinical expertise and practice.

Early on we recognised that if we didn't take a lead on collecting data and measuring quality ourselves it would be done to us, as has happened elsewhere – for example the inpatient specialties which had PHIN's methodology and measures imposed upon them.

We've considered what is most appropriate for the private sector, whilst mindful of the NHS direction.

We recognise however that we don't have a role to mandate specific measures, only to share our findings and recommendations, so our approach is to nudge, not to push. Equally, we want to minimise any bureaucratic burden but add value for all parties.

In 2017 and 2018 we held two open forums on this work and have incorporated their feedback in our recommendations. A separate online survey in early 2018 painted a picture of a very fragmented market which uses a diverse range of quality measures, and some providers none at all. This means comparisons are not possible. Standardisation is needed to enable this and would be to the sector's advantage. Most providers see the benefits for clinicians and patients.

Our work is aligned with that of the CQC – it's about quality, rather than focused on financials or promoting the bottom line.

Our priorities were to identify systems and processes that are useful and easy to administrate for clinicians, hospitals and insurers, and relevant for patients. As this is about measurement, we wanted measures that are valid, suitable and sensitive to change.

We have given importance to cost, time and other practical implications in our recommendations in order to minimise reasons why providers should have an excuse not to participate. It is also important that this should be as easy for small as large organisations to implement.

Benefits for all

All

Brings together providers, commissioners and patients into shared dialogue about quality.

An outcomes-focused culture will help define the value of the care or services provided and promote the most effective pathways whilst potentially removing unnecessary processes.

Clinicians

Understand how effective their treatments are at an overall level and how they compare with peers.

Better clinical decision-making by use of consistent and comparable assessment of patient status and preferences

Demonstrate to patients what a quality product looks like and use this evidence to educate them around expectations of treatment impact.

For those delivering better quality, greater competitive strength

Greater priority given by insurers to clinicians who either collect quality data or have demonstrably better outcomes and value.

Patients

Patients are better informed about treatment prospects, choices and results. This information should enable better conversations with clinicians, better decision-making and better outcomes.

Give confidence in selected clinician.

Evidence for the circumstances and behaviours which promote the best outcomes.

Insight into treatment impact compared to patients with same condition – either as reassurance or as an alert

Quality as a commodity to consider when purchasing private MSK treatment

Enables patient input around personal priorities and values, so clinicians and patients become co-creators of care.

Provider organisations and managers of clinicians

Evidence to reflect upon their clinicians' strengths and weaknesses

'Hawthorn effect' to drive improvements to quality of clinical practice by reflecting on factors that contribute to better outcomes

Motivational feedback and evidence for clinical revalidation

Use of quality data in commercial negotiations with insurers

Evidence-based marketing

Insurers and commissioners of care

Outcomes used to evaluate quality and effectiveness of providers, care pathways and treatment types, so that the following can be done:

Identify risks with providers

Incorporate quality as a factor in provider selection processes, giving higher priority to those either collecting quality data or at a later stage rewarding providers delivering better overall value.

Represent the interests of customers and assure them of quality standards

Ensure the right interventions are being carried out

Forecast emerging trends and take action (care, policy etc.)

Business reporting about quality as well as cost

Use evidence to promote business growth

Findings: On the process

The working group is not offering a perfect solution but a sensible and tangible starting point which can be developed in future, now that we have considered the options. This will start as a data collection process, drawing on different input systems, that in time can become a quality measurement process and definition of quality in private MSK care that is intended to help patients, clinicians and commissioners understand relative quality and help the industry grow.

This should result in a brand for quality in the private sector that consumers really understand, as has been done in the telecommunications industry and elsewhere.

For this all to function effectively we need a critical mass of stakeholders to participate. All representatives in the working group have the support of their organisations to facilitate this.

We recognise that between individual practitioners and large provider organisations there will be a wide range of data collection capabilities. For this reason at an early stage we think it is important not to dictate a particular model of data collection (paper, application, spread-sheet, website etc.). However we can and should be prescriptive about the output required for analysis and comparison.

Each provider's choice of model will have consequences about ease and costs of collection. Cost should not be a barrier, especially for smaller providers

It will take time from the start of collecting data before we understand what the measures and standards of quality in private MSK look like, so we will need to manage everyone's expectations on this point. Until this happens, what we will have is a collection of data that is quality-related rather than a direct indicator of quality. We will need this to be expressed in a format and language that is easy-to-understand rather than complex and academic.

We need to show the range of what's valid and reliable, the pros and the cons – but we can't do more than that. We recognise that it is good not to be too prescriptive early on; walking before running, and learning from lessons as this is tested and implemented.

Findings: On patients and providers

We want patients to be involved in this process to ensure that it works for them and draws on their input to make it even better, as well as involving them in their assessment of the quality of clinical care.

High response rates from patients and clinicians are important for the validity, confidence in and credibility of results, as well as a sign of commitment by providers to this work.

We acknowledge that whilst many in the sector accept the need for quality data and its value for patients, clinicians, intermediaries and commissioners, some in these four categories may not attach the same importance to quality, as in any other service or market. This means that evidence-based quality can become a differentiator for those who value it. There will be mutual wins for those who wish to work together to create and use a meaningful framework of quality.

Providers should note the importance of enabling the right culture which values and promotes the importance of outcomes to staff and patients. We should want to have clinicians seeing this as worthwhile and in their interest. In some cases new resources may also be needed to facilitate successful delivery of quality measurement and its use, including IT and staff.

As most providers currently have no idea how they compare with their peers, this process may be both new and fearful for many of them. However this will offer them the chance to learn what they are good (and less good) at.

For this reason clear communication and the support of clinicians are of critical importance, also for the transformational impact this can have on how providers are valued.

Findings: On insurers and commissioners

One key objective of the group has been to avoid different insurers each requesting different quality indicators from providers. This is an example of cross-functional working with a shared vision across the sector.

At the earlier stages, to offer reassurance to providers on the data we strongly propose an embargo on its active use by insurers. This means that data would first be collected, and providers would have the chance to reflect on their practice and improve this before insurers would get an updated version of the data and start using it. This should form part of our contract and communications with the wider MSK community.

The use of quality data will have implications for insurers, too, in terms of their relationships with their providers, their customers and how they manage their commissioning. This will be a significant change to culture and will enable patients, providers and commissioners to discuss value, not just activity: it offers the potential for all relevant stakeholders to be partners with a shared agenda and culture of improvement.

We agreed that insurers should distinguish between providers that do collect and those that don't – the former should be rewarded by insurers for their efforts. Equally this will inevitably lead towards measurement of participation levels – simply collecting data once in a year is not the same as regular and comprehensive measurement.

Insurers will need to be clear on how they will and will not use this data, include their support for the process and reassurances to patients on their anonymity being safeguarded as well as to state that this won't affect people's insurance premiums.

Findings: On the use of data

The work required to report and measure quality of care should be seen as part of good clinical governance and professional standards.

How the data is used all will require focused attention in terms of:

- Who will have access and who won't
- At what level of detail will access be given
- How it will be used and how it will not be used
- Expected sequence and timeframe to full implementation

Data quality will be of great importance. We don't want inaccurate insights. We also know that it can be easy to spot results that are unrealistically good and that we should encourage a culture of openness that accepts that in some cases or on some days things may not go as we wish, but that important learning can result from these experiences.

We want to promote the examples of the top performers and use this data to better understand the impact of the latter. Ultimately on a benchmark of quality whilst 50% of providers will be above average and the other 50% below average, it doesn't mean that the latter are necessarily 'underperforming.'

Nor do we want to provoke a race of price to the bottom.

Instead as a suggestion it may be appropriate to look at those whose quality and effectiveness is at two standard deviations away from the norm, where 95% of providers might perform as we would expect, and 2.5% on either side would be exceptionally high or poor performers.

The proposed dataset will enable analysis on geographic variation based on the postcode of the practice. We recognise how some patients will travel further for their treatments, so this is an important element to record alongside other categories which enable case-mix adjustment including age and gender.

Quality

What might be the recognisable characteristics of a high-quality provider?

- High patient satisfaction scores
- High positive impact on patient wellbeing and function whilst similarly reducing pain and discomfort
- Low or zero rate of complaints
- Low or zero rate of safety or other clinical incidents
- Efficient use of time / resources to achieve a quality result for the patient

- Collection of high rates of quality data in each domain as a proportion of total volume, e.g. of PROMs (Patient-Reported Outcome Measures) and patient satisfaction feedback.
- High volumes of patients, indicating high frequency and familiarity of clinical practice as opposed to occasional practitioner
- Broad consistency of results rather than significant variations

For validity these scores should be adjusted for case-mix:

1. Some providers will choose to offer services to all types of patient (conditions, demographics, severity).
2. Others may focus on lower severity or more complex cases; for certain types of the body or potentially for certain patient types (e.g. older or younger patients). There should be no penalty for taking on the more difficult cases and we recognise in advance that improvements for their health and ability may be more limited.
3. Where appropriate, onward referral rates may need to be case-mix adjusted depending on the type of patient condition or the type of clinician

Implementation

We see our role simply as a collective of people and organisations who are trying to facilitate the introduction of standardised quality measures in private musculoskeletal care, and we welcome all support and ideas that can help in this.

We have to start simple with embedding a data collection process. We can't do everything in one go – e.g. store, analyse, benchmark data – but we have acknowledged the intended final destination.

There are many things we could measure (e.g. return to work, patient profession, duration of symptoms before treatment start, etc.) but we focused on what was collectively found to be the most important measures and data, at least at the initial stage.

After data collection will come analysis and validation to identify variation in practice or other factors; later still will be publication and comparisons. The ultimate direction is recognition & reward by insurers and the market for demonstrably high-quality care.

All patients should be invited to participate; otherwise selecting only certain categories of patients will lead to confusion, complexity and lower rates of completion.

Patient data that is aggregated should not include their personal names. This should reinforce patient trust in the process and their clinician. Our discussions have shown that commissioners interested in the quality data at a condition- and provider-level, not at the individual patient level.

A simple and clear statement about how patient information will be used should be given by providers, with an option to opt-out. We can include audit and research purposes as part of the purpose of collecting patient outcome data.

Implementation - more

We strongly encourage electronic processes which facilitate sharing and use of data; paper formats do not enable easy analysis. However we also recognise that some organisations prefer paper processes; they will need to have to convert this to electronic format, with associated risks of errors in transcription. Regardless of process, all outputs need to fit standardised template and be in digital format.

Initially comparisons can only be made by organisation. Only with a great deal of data can individual clinician comparisons be made for them to have sufficient validity.

Case-mix adjustment will be possible only when we have high rate of collection of diagnostic and procedure data and associated high volumes of customer data recorded.

One key step will be the process to identify and nominate an independent, neutral and suitably-qualified institution to analyse and report on the data. This complex piece of work may require agreement and commitment to funding and oversight. It was agreed by the working group that the first priority should be establishing a dataset first that is sufficiently robust for all.

Proposed dataset for each patient / intervention

Basic details												
Provider ID	Lead clinician ID	Anonymised patient ID	Gender	Age or age-band	Co-morbidities	Diagnostic coding system	Condition code	Condition description	Treatment type or group e.g. from physiotherapy, chiropractic, orthopaedic, osteopathy	Date of treatment start	Date of treatment end	Number of sessions
A2B MSK services	SWA	1001	M	60	Asthma	OSICS	AJXX	Ankle sprain	Physiotherapy	01/07/2017	31/12/2017	6

Patient-reported outcomes									Incidents and complaints			
PROM used	Date of initial PROM completion	Initial PROM score	Date of final PROM completion	Final PROM score	Patient satisfaction measure	Date of patient satisfaction survey response	Patient satisfaction score	Treatment outcome status	Description of complication, clinical incident or other safety-related event	Date reported	Category of complaint (Administration, Clinical care, Financial)	Date reported
PSFS	01/07/2017	3	01/12/2017	6	NPS	15/12/2017	8	Onward referral	N/A	N/A	Administration	29/08/2017

Notes

Provider ID should be the specific provider (including location, e.g. Six Physio Moorgate) rather than the generic provider (e.g. BMI).

The working group agreed that treatment types should be categorised as the type of intervention (e.g. osteopathy) – that any more detail at this stage was unhelpful and unnecessary.

For complications, clinical incidents or other safety-related events these would include any injuries that directly result from treatment.

Diagnostic coding – options with pros and cons

We encourage use of validated diagnostic systems and processes which enable clinicians to quickly and easily identify and record a precise diagnosis.

Of all the topics discussed by the MSK cross-functional working group this was the one which resulted in the greatest divergence in views. Some are keen to have very simple categories of diagnostics – body parts – whilst others are seeking far more granular detail.

Own system
- Lack of comparability or benchmarking.
- No extra costs, but no benefits either.

Body parts
- Provider to list each patient's affected body part e.g. knee, shoulder
- Simple and easy for clinicians to understand.
- The same body part may be affected by different injuries or conditions, each of which will has different treatment needs and recovery behaviour: Valid analysis depends on like being compared with like.

Physio First QAP scheme
- Physio First's Quality-Approved Practitioner scheme also has its own bespoke validated diagnostic coding system used by its members who are chartered physiotherapists.
- This may be of interest to others within the physiotherapy community but by its very definition excludes all other outpatient MSK treatments.

ICD-9/10
- NHS and many private hospitals use the ICD-10 system.
- However it does not cover outpatient MSK in any depth: these conditions are covered solely under the umbrella code 71900, 'Other and unspecified disorders of joint.'
- For useful insight into patient conditions and comparison of outcomes a more developed diagnostic system is required.
- No cost, but equally no insight.
- We cannot do meaningful outcome collection and analysis without a proper understanding of patients' conditions.

OSICS (also known as Orchard codes)
- Covers a wide range of sports and outpatient/inpatient MSK-related and orthopaedic conditions in great depth
- Its tree structure means that you can go into as much or as little detail as needed
- Can only do one diagnosis – i.e. does not cover patients with complex or multiple conditions.
- All codes or a selection of commonly-used ones could be incorporated within an diagnostic coding system such as ICD-9
- Adoption would require agreement and co-ordination between providers and insurers.
- No licence charging; just clear disclosure of its source (John Orchard)
- Like any new process it will require agreement and training

Snomed-CT
- A clinical terminology system that encompasses all healthcare-related conditions (over 300,000), developed by the NHS and the College of American Pathologists.
- The health industry is moving towards this as its standard, with the NHS targeting a transition date of 2020.
- Provides more granularity than OSICS – as much detail as we might ever need.
- Requires a web-browser, but there is a licence charge
- From an operating perspective it may be costly and complex to implement as a transition from any existing system
- Created for clinicians and has clinical validation, but because of its approach does not require use of a clinical coder, unlike ICD-10.
- This is supported by the CSP
- Some limitations on what's been defined within Snomed so far (e.g. types of ACL sprains).

Bridging tables
- Involves the conversion of codes from e.g. OSICS to ICD-10, or ICD-10 to Snomed
- Enables everyone to retain existing systems.
- However not all systems have conversion / look-up tables
- No training requirement.
- Some systems record more detail others will not so there may be a loss of insight in the conversion.

Patient experience: Overview

Completing surveys should not be compulsory for patients, but every patient should be invited to participate. Low participation rates may not give a reliable or representative view of quality.

This should be seen as clinician-led and collected directly by providers, rather than commissioners, and for the purpose of fairly assessing the quality of care rather than for commercial reasons.

The process should be managed in ways that are independent of the clinician for unbiased responsive, easy to administrate and inexpensive: convenient for patients and clinicians alike. Nor should it interfere with clinical treatment time.

For both patient experience and PROMs (where applicable), an automated capability to analyse free-format comments and identify key themes is of significant value especially where patient volumes are large.

Patient experience: Options

There are several options:

1. **Own system:** No like-for-like comparisons or benchmarking capability
2. **NHS friends & family**: Free, 2 questions, applicable to MSK. Enables benchmarking with NHS. Offers limited differentiation on results – most providers score 95-100%.
3. **Net Promoter System**: Free, 2 questions, used by many private organisations. Offers much stronger differentiation – range -20 to +80.
4. **Other methods** e.g. PSQ-18, CAHPS, Oxford Experience Questionnaire: These often contain 10 or more questions, may identify specific issues and may require a licence.

Providers should consider their method: paper or electronic (app, website, email, text message; onsite via ipad or at home) and the processes to facilitate its collection and reporting. Both paper and electronic formats involve costs, though the cost structures are different.

Paper has lower set-up costs and may feel easier to administrate. However the conversion of paper-based responses to electronic formats creates work and the risk of errors particularly where there is poor handwriting.

Electronic patient feedback systems have higher set-up costs but once in place are easier to administrate and share or analyse; there may also be lower on-going maintenance costs.
It is also easier to validate the authenticity and accuracy of electronic feedback.

The point in time when the survey is given to the patient may also affect results, depending on other factors e.g. if longer-term recovery is not sustained or if the clinician changes or new costs are added. Ideally it should be collected towards the end of the treatment, so the full experience can be reflected in the results.

Health impact (PROMs): Overview

Clinicians should be directly involved in selecting the most appropriate measures for their service whilst checking that they meet the needs of patients and commissioners too.

The chosen Patient-Reported Outcome Measures should be easy for patients to understand and fast to complete so we get high rates of participation.

Equally the methodology should be easy for clinicians to administer.

To avoid bias or influence patients should complete PROMs without any direct involvement from the clinician, other than their contextualising the survey and affirming its importance.

At the minimal level PROMs involve patients completing a survey at the start and end of treatment, comparing ‘before’ with ‘after’ to measure the difference effected by treatment.

Ideally PROMs are collected throughout the course of treatment. For programmes of multiple sessions, if we only request a ‘before’ and ‘after’ we may risk losing the ‘after’ results if the patient fails to turn up for their expected last session or if the survey is not remembered. For this reason use of a short, unintrusive PROM is strongly recommended.

As with patient experience, every patient should be encouraged to complete PROMs.

PROMs will enable customers to assess not only the effectiveness of the provider but in the longer term potentially to choose an insurer too as their policies, processes and support teams may influence outcomes.

PROMs should not be seen or used by clinicians simply as a retrospective tracking tool, but also prospectively to monitor and adjust for patient progress versus expectations.

Health impact (PROMs) – Factors to consider

When choosing a PROM supplier

- Pricing (both set-up and on-going costs)
- Reporting capability for clinicians e.g. improvement scores, completion rates etc.
- Automated alerts for patient scores that raise any clinical concern
- Ability to track which clinicians and which patients are (not) submitting results and to prompt for these directly from within the system.
- Data capture processes and case-mix adjustment capability to ensure like-for-like comparisons e.g. profiling results by condition or by intervention type etc.
- Ability to access / download own data rather than have it held by service provider
- Ability to show personalised PROM benchmarking for patients to support their participation and offer value back for their contribution
- Helpdesk facility

When choosing a PROM (measure)

Some PROMs have been designed more with patients in mind for their convenience and value, others more for clinical research and the interests of academics.

- Number of questions: fewer questions may make the questionnaire more attractive to complete; also are the questions useful and relevant – do they give clinical insight on the patient's condition, functional ability, pain etc.
- Validity e.g. academic reviews
- Cost of licence: some may be £5-£15 per patient, which quickly adds up
- Ability to compare e.g. with peers or NHS
- Ease of language / comprehension
- MSK focus
- Sensitivity to change – i.e. if patients typically all score 9 or 10 out of 10 this does not allow useful differentiation.

PROMs – A selection of the most relevant & popular

Patient-specific Functional Scale (PSFS)
- Up to 3 questions
- Focus on patient's desired goals for their treatment
- Free; easy to use
- Validated e.g. against Roland-Morris
- Patient-centric and can easily be incorporated in natural conversation.
- Patient goals vary substantially, so comparisons are not like-for-like.
- Works best if goals are agreed as realistic with clinician

MSK-HQ
- 14 bio-psycho-social questions focused on aspects of MSK-related quality of life and symptoms
- Much more responsive than EQ-5D
- Good comparability with Oxford surgical scores
- Can calculate economic benefits in QALYS to enable value-for-money / impact comparisons
- Still under trial but starting in NHS in 2020; not fully validated in the wider population.
- The number of questions may be off-putting for patients and/or clinicians: this may feel like a box-ticking exercise
- Licence cost will be required for non-NHS use
- Very strong branding association with Arthritis Research UK – may alienate non-arthritic patients

Condition-specific e.g. Womac, Oswestry, Dash, Koos, IKDC
- Many to choose from; most are surgically-focused and more academic than patient-friendly
- Licence normally required
- Most contain 10-20 questions

Global Rating of Change scales
- 1 question asked and reported by clinician rather than patient
- Personalised to patient's condition; frequently used in MSK
- Free and validated
- Depends on ability to remember pain at previous point in time (before treatment) and compare that with now.

EQ-5D
- Generic questionnaire used in NHS
- 5 questions
- More relevant to surgical care; not very responsive for outpatient MSK
- Licence payable for non-NHS providers

Physio First Quality-Assured Practitioner scheme
- For physiotherapy only
- Requires membership of Physio First / fee
- 21 questions including PROM but also other factors e.g. demographics, funding, goals and diagnosis
- Validated by University of Brighton

Bournemouth (all MSK; adapted)
- 7 questions covering bio-psycho-social aspects of MSK wellbeing
- Widely used in chiropractic care as well as osteopathy
- Initially for lower back pain; adapted version for all MSK
- Appears to be free of charge, with no need for licence

VAS (Visual Analogue) / National Pain Rating Scale
- 1 question focusing on pain
- Free, validated, easy to use

Measure Yourself Medical Outcome Profile (MYMOP)
- Patients generate and score individualised questions on symptoms, activity, wellbeing and medication.
- Calibrated to the patient's experience and priorities.
- Questionable utility in using collated data given individualised questions
- Good responsiveness
- Validated and free for use

Reference: The working group


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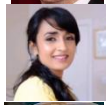
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