CROSS-PARTY GROUP ON ARTHRITIS AND MUSCULOSKELETAL CONDITIONS

MINUTES OF THE MEETING ON 19 MARCH 2014 INCLUDING AGM

Election of Office-Bearers

1. Nanette Milne chaired the AGM; Margaret McCulloch was appointed Convenor (nominated by Jim Hume and seconded by Jim Eadie), Nanette Milne, Deputy Convenor (Margaret McDougall and Anne McTaggart) and Sheila MacLeod, Secretary.

2. New MSP members were most welcome.

3. Margaret McCulloch chaired the remainder of the meeting. She paid a warm tribute to the commitment and hard work of Helen Eadie who had contributed so much in the area of arthritis and musculoskeletal conditions. She was proud to carry this work forward. **Members asked that a letter be sent to Helen's family in recognition of all she had done.**

Minutes and Matters Arising

4. The minutes of the meeting on 27 November 2013 were accepted.

Outline Forward Programme

5. The forward programme for 2014 had been issued to members and was noted.

Research in Rheumatic Disease at the University of Aberdeen

6. Gary Macfarlane, Professor of Epidemiology, outlined the Aberdeen research programme, on the basis of which it had been awarded recognition as a European League Against Rheumatism (EULAR) Centre of Excellence.

7. Chronic pain, as defined, was a common condition affecting 13% of the adult population, significantly limiting the capacity to work and to function generally. Pain acted on a physical continuum

from specific to widespread; where widespread and chronic it became Fibromyalgia, a condition whose origins appeared to lie in some combination of physical trauma and emotional stress. The 1958 Birth Cohort Study revealed that involvement in a road accident before the age of seven to be an important predictor. Evaluation of disease management initiatives - individually tailored exercise programme or Cognitive Behavioural Therapy (CBT) delivered remotely – indicated a significant improvement in positive outcome for both, with CBT slightly ahead, but no additional value in sequential participation in both. This therapy could be delivered well within the parameters of NICE-defined cost-effectiveness. Next steps might be preventative intervention and public health campaigns.

8. Richard Aspden, Professor of Orthopaedic Science, indicated the scale and severity of the problem constituted by Osteoarthritis (OA); joint replacement was highly effective but prevention would be better; back pain was the most common work-related injury and had huge costs. The disability caused by these conditions had very significant psychological as well as physical implications along with severe reduction in social, cultural and economic engagement. Traditionally regarded as purely wear and tear, OA needed to be seen in the context of the whole person – joints, all other tissues, obesity, family history and the wider health picture. If there were the possibility of regeneration of tissue in the early stage of the condition this would argue for early diagnosis and intervention. Taking into account the biomechanics of the back and hip, in all their individual variants, was an important factor also in making progress. The multidisciplinary approach in Aberdeen helped draw together these important elements.

9. Dr Neil Basu, Consultant Rheumatologist, regarded his research as driven by the concerns of patients of whom 60-80% report clinically relevant fatigue – as defined, a highly debilitating and sustained exhaustion which severely limits ability to function or work. Respondents in a study of ANCA Associated Vasculitis identified fatigue as the main determinant in both diminished quality of life and work disability. These results were mirrored in other rheumatological conditions and borne out in a recent National Rheumatoid Arthritis Society Scottish study. Non-pharmacological fatigue management programmes have had measurable but relatively small success. Looking at the brain in the context of fatigue has indicated there may be some

abnormalities present in patients with the condition, pointing to the possibility of targeted drug intervention. Future approaches might include neuro-imaging, looking at immune biomarkers and clinical trials of interventions.

10. Questions and discussion raised the following –

- Difficulty for healthcare professionals in accessing CBT for their patients might prompt exploring a wide range of innovative approaches – telephone, internet and Skype as well as training the professionals involved in the primary condition, rheumatological or other, to deliver.
- In the context of Ankylosing Spondylitis and fatigue, which is the subject of current research in Aberdeen, CBT would not replace but might complement drug therapy.
- Researchers naturally take the view that resources and support available for research, especially in relation to non life-threatening conditions, are never adequate. The pharmaceutical industry is pulling out of OA research as, in the nature of the condition, drug trials take a considerable time.
- In terms of an integrated response to research certainly more joined-up thinking is needed.
- In treating complex conditions healthcare professionals need all means at their disposal; all need to be effectively validated, as an evidence-based approach is fundamental. Some evidence for complementary therapies exists but it is inadequate due to lack of trials.
- SIGN Guidelines are certainly helpful but full implementation is always the challenge.
- It is as yet unknown whether prescribing costs will come down once biologic drugs are off-patent. Treating long-term conditions raises major affordability issues.

Allied Health Professionals and the Integration of Health and Social Care.

11. Kenryck Lloyd-Jones updated the Group on the recent passage into legislation of the Public Bodies Joint Working (Scotland) Bill and its implications for Allied Health Professionals (AHPs) and for those supporting the interests of people with arthritis and musculoskeletal conditions. The integration of health and social care aimed to improve the interface between these two

services and, against the background of an ageing population and the prevalence of long-term conditions, to find better ways to deliver care. Everyone was in favour of joined-up provision but the challenge, of course, lay in delivery, with structural, cultural and financial issues to be overcome. A shift in focus towards prevention, early intervention and treatment in the community rather than hospital would be fundamental; the role of the AHP would be central to the integration agenda with AHPs acting as the glue in the system. Concerns that they might not be fully engaged in the process had been allayed to some extent by the Scottish Government response to representations about AHPs and Community Health Partnerships. The AHP Delivery Plan was helpful but, as the integration process progressed, the position of AHPs should be kept in view.

12. The following points were made in discussion –

- AHPs work across the hospital and community sectors, thus knowing what integration means in practice. There is a problem about the public properly understanding their role.
- Integration was certainly important; but how was it best to be carried through; the patient, a generalist in outlook, needed services which were transparent and accessible.
- Attitudes of those who run the system and the words they use to describe and define it are what need to be changed, not just structures.

13. The next meeting would be on Wednesday 25th June.

14. Margaret McCulloch closed by thanking all concerned and, in particular, the speakers for their excellent and stimulating presentations.