Document Summary

The Faculty of Sport and Exercise Medicine have produced this document in order to give local commissioners a template to use in order to provide a tender document for an MSK service for that area.

The document is intended as guidance, to be adapted as required, but is based on current "best practice" and has gathered the views and advice from MSK specialists nationally.

It highlights the advantages of a Medical Specialist-led, multi-disciplinary service working closely/integrated with community and secondary care providers, in order to give the patient a streamlined and coordinated approach to their care for an MSK-related issue.

Why have an SEM/MSK Consultant lead?

Although this may not be available in all localities, SEM/MSK Consultants are uniquely placed to lead this service.

Reasons why a Consultant (or MSK Specialist Dr) - led service is advantageous include:

- Specialist training to manage complex medical and surgical problems
- Working knowledge and experience in Primary and Secondary Care settings
- Experience in leading and managing a multi-disciplinary team
- Consultants in SEM are experienced at dealing with complexity and have huge experience. As Doctors, they are permitted to exercise clinical judgement, enabling them to individualise each patient's care beyond protocols. The GMC and indemnifying bodies permit doctors to work in this way
- Doctors are uniquely placed to deal with uncertainty and complexity
- Any guideline or protocol can fail to identify a safety issue and doctors are well placed to exercise their unique skills and judgement to ensure that no patient has a misdiagnosis
- The Consultant also has huge expertise in teaching and leadership. This will improve quality of staffing for the future. They can help with induction and re-writing of protocols that fit with current practice and learn from safety incident occurring in other places

More information on the training and skills of SEM/MSK consultants can be found on the Specialty Training Curriculum Document 2010 <due to be updated 2020> (https://www.jrcptb.org.uk/sites/default/files/2010%20Sport%20and%20Exercise%20Medicine.pdf)

Consultant-led teams lead to an overall reduction of onward referrals into secondary care specialist departments and hence reduce overall costs and patient journeys.

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1. Main Purpose

1.1 National / Local Context and Evidence Base

Musculoskeletal (MSK) disorders include a range of conditions that affect the muscles, bones and joints of the human body, affecting every day activities. Musculoskeletal conditions are extremely common and the incidence tends to increase with age.

This guidance outlines the requirements for the provision of an Integrated Musculoskeletal (MSK) clinical assessment and treatment service for an NHS locality. The service model will include treatment pathways for physiotherapy and podiatry, and will be responsible for designing and providing planned care for all MSK specialties. It spans across primary and intermediate care services, and interfaces with secondary care, to plan MSK pathways with patients, ensuring they receive the right care, at the right place at the right time in accordance with their needs (GIRFT principle). The specific focus of this approach will be on early assessment and cost effective, evidence-based clinical interventions, aligned to patient outcomes.

The prime provider will create a division of services with an integrated multi-disciplinary clinical team providing triage, assessment and clinical treatment expertise across MSK sub-specialties as an alternative to secondary care treatment (excluding trauma, red flag conditions & acute admissions), reducing dependency on hospital based services and delivering as much care as possible in the community. This ensures that patients are only referred to secondary care when there is a specific need for hospital-based treatment. The majority of initial assessments should be undertaken in Primary Care, by GPs with appropriate MSK skills and training and/or (depending on locality needs and skill-set) by First Contact Practitioners (FCPs) working in GP surgeries, as part of the MSK service, with further triage and treatment to be filtered through the single point of contact at the front end of an MSK hub.

The principle aim of the hub is to deliver MSK care navigation and a service that:

a. Improves the patient experience and delivers high-quality clinical outcomes through shared decision making, patient engagement and supported care plans
b. Ensures that clinical, quality (patient) and financial outcomes are fully aligned, integrated and realised
c. Significantly reduces clinical variation for patients with MSK conditions through effective monitoring, planning and ongoing service improvement to deliver streamlined care
d. Reduces low clinical value interventions, improves waiting times and reduces referrals onwards to secondary care
e. Provides seamless integration between tiers of care
f. Includes (agreed) protocols that ensure planned support for patients following discharge from hospital care back into the community
g. Provides access to and supports patient self-management, including access to pain management programmes and support that enhances patient quality of life and independence

h. Enables the patient to understand their health and how to improve this in general with exercise, beyond their current condition

i. Allows the opportunity to use Peri-Operative care, so that patients who eventually require surgery and those for whom surgery is an option, improve their physical, mental and emotional health prior to the surgery, at this 'teachable moment', with fewer complications and potent lifelong health benefits. For example, improving aerobic fitness, balance and strengthening reduces heart disease, dementia and depression and helps treat many other long-term conditions

2. Population needs

2.1 National Context and Evidence Base

MSK Conditions affect millions of people, creating a significant social and economic impact.

The NHS currently spends around £4 billion per year on musculoskeletal services, with around 1 in 4 adults in the UK affected by long-standing MSK conditions. MSK problems currently account for approximately 20% of all GP consultations and are the most common reason for repeat appointments with a GP. 40% of all adults in the UK over the age of 70 have osteoarthritis of the knee and an estimated 8-10 million people suffer with arthritis. These conditions have a major impact on people's lives - loss of physical and social functioning, chronic pain, sleep disturbance and depression. 1 in 5 people currently receive incapacity benefits due to MSK conditions.

An ageing population will further increase demand for treatment of degenerative disorders such as osteoarthritis, with the associated loss of function, loss of independence and increasing frailty. People with musculoskeletal conditions will continue to require high-quality support and treatment, ranging from simple advice to physical therapies and specialist medical and surgical treatments. The incidence of MSK conditions is strongly associated with age however increasing obesity, reduced physical activity and associated co-morbidities will also impact on musculoskeletal health of younger people.

NICE guidance states that frailty is not inevitable and is reversible.
(https://www.ncbi.nlm.nih.gov/pubmed/29042359)

3. The Case for Change

Findings from the Joint Strategic Needs Assessment (HCC 2017) identified four strategic issues and recommend that MSK service models:

- Include measures to reduce clinical variation in musculoskeletal care
- Take account of the future MSK needs/demands of an ageing population
- Place an emphasis on primary and secondary prevention
- Encourage greater use of self-management and shared decision making

Access to physiotherapy is variable but generally slow, and all MSK services need to change to manage and deliver against growing demand. Access to a comprehensive and multi-disciplinary Pain service is often inadequate, with approximately 80% of chronic pain referrals being MSK related.
In a changing NHS environment, there is a need for collaboration between primary, intermediate and secondary care.

Currently NHS services are primarily organised to be reactive to illness rather than proactive to prevent crises and maintain independence, including the scope for early intervention. Provision of adequate community physiotherapy and occupational therapy, particularly to the frail elderly, for both prevention and rehabilitation, is inadequate. The result is preventable falls, pressure on Emergency Departments, delayed transfers of care, extended lengths of stay in hospital and pressure on limited resources.

It is vital that clinicians have a greater appreciation that good prevention and supported self-care, (ideally commencing in primary care) may be more beneficial to patients than surgery. That means that in the future there must be a greater emphasis on 'health gains' based on the intervention proposed for the patient, and requires clinicians to use knowledge, experience and skills to make informed decisions based on individual patient needs. A key outcome for this service provision is to implement standardised assessment methods and streamlined referral processes based on local protocols, compatible with national guidelines and that the MSK workforce adhere to.

The development of a "hub-and-spoke" model provides the opportunity for first appointment and follow-up activity at primary care level, while being part of the broader MSK service. This will help to ensure that clinical variation is kept to a minimum, and resources and referrals are managed according to clinical need.

In summary the current ways of working are not sustainable given an ageing population, changing needs, growing demand, long term conditions/co-morbidities and a challenging financial position. The case for change is no longer a choice, but an imperative.

4. National and Local Defined Outcomes

4.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	X
Domain 2	Enhancing quality of life for people with long-term conditions (LTC)	X
Domain 3	Helping people to recover from episodes of ill-health or following injury	X
Domain 4	Ensuring people have a positive experience of care	X
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	X

4.2 Local Defined Outcomes

The MSK model should include clinical assessment and treatment, with individual care-planning and shared decision-making in keeping with NHS Constitutional Standards and the Clinical Commissioning Group's principles of 'choice'.

MSK services should be made available in locations that are geographically convenient with good transport links. They should take into account the geography of the locality and acute care systems.

The Service should provide a daily triage service Monday to Friday, with paper triage of referrals being ideally undertaken within two working days (48 hours) of receipt.

The Service will work to continuously improve efficiencies including alternative means of service provision e.g. non-face-to-face, follow up, telephone triaging service and embed productivity improvements as standard operating procedures. This should make best use of Information Technology for example include the use of smart-phone apps, a hotline telephone/text number, a dedicated e-mail address or a web-based solution.

The service must keep the patient's registered GP informed of progress along the pathway. Communication should include:

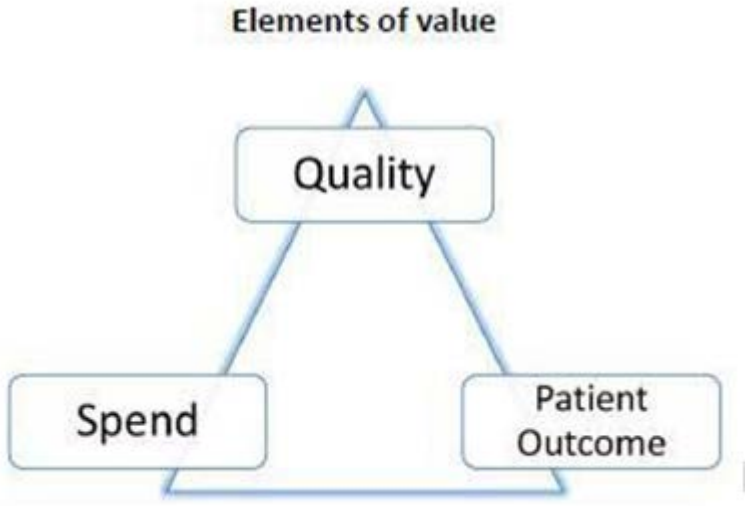
- Confirmation of a patient's acceptance into the service and a summary of the proposed treatment plan following the first appointment
- Details of any proposed medication changes, especially where the GP is the primary prescriber
- Confirmation of discharge from the service with a clinical management plan

The service should work in partnership with Primary Care Networks (PCNs), providing systematic feedback in relation to sub-optimal referrals, educational updates to referring clinicians, and provide education and support to patients to empower them to make informed decisions and be proactive in co-producing and managing their health and wellbeing.

The following list shows some of the overarching national principles that will also be considered:

- Reducing avoidable emergency admissions
- Reduction in the need for urgent care
- Reduction in unnecessary days spent in hospital
- Increase in health-related Quality of Life for patients with long term conditions, including mental health
- Value for money
- Increased patient and carer satisfaction with services, including improved responses to the Friends and Family Test for local services
- Reduced mortality - potential years of life lost for conditions amenable to healthcare
- Working with the patient to understand the huge benefit of exercise and physical activity to their health as well as MSK functioning
- Supporting patients to feel comfortable increasing their exercise, thus improving their cardiovascular fitness, reducing their risk of type 2 diabetes, mental ill-health and other conditions
- Introduction to personalised advice, so that their health improves for the present and for the future

The key objective of any commissioned service is that the population receives the best personalised (MSK) services in accordance with their needs, in a timely manner using a shared decision making approach. This is underpinned with the ethos of providing the right care in the right place at the right time at the first time of asking; with a focus on quality, spend and patient outcomes as illustrated below:



Quality, spend and patient outcomes will only be delivered effectively and sustainably if patients experience a (effectively monitored) reduction in clinical variations. Exception to variation is based on evidential and clinical need, and relative to patient outcomes.

5. Service Requirement

The service should receive referrals from Primary Care, Secondary Care and FCPs (if required) to triage, assess, diagnose, treat or transfer the referral as clinically appropriate, within the locally commissioned referral to treatment timeframe. The service should be delivered in line with all applicable national standards and guidelines in the NHS England (October 2015) guidance[1] on recording and reporting referral to treatment (RTT) waiting times for elective care.

The service should include holistic patient assessment and development of individual treatment plans, delivered by a Consultant-led (ideally an SEM/MSK consultant with FFSEM) multi-professional team including but not limited to (depending on locality needs and location):

- Other Sports and exercise medicine practitioners (preferably with MFSEM but also a diploma or MSc in SEM)
- MSK General Practitioners with Extended Roles (GPwER) (previously known as GP with a specialist interest. GPwSI) – preferably with the FSEM MSK Diploma to show minimum competence
- Extended Scope Practitioners (ESPs)
- Other Physical Therapists
- Clinical Psychologists
- Occupational Therapists
- Exercise Professionals
- Rehabilitation assistants and technical instructors
- Nursing and Specialist Nurses
- Podiatrists to provide specialist foot biomechanical assessment and management, including orthoses (NOT a chiropody service for nail and foot care)
- Ppatient 'choice' / administration coordinators who are appropriately trained and competent
- Consultants (including Pain Management and Trauma & Orthopaedics)

[1] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Recording-and-reporting-RTT-guidance-v2[1]4-2-PDF-703K.pdf

Often described as a 'Tier 2' or 'Intermediate Level Service', the service should play a key role in the management, coordination and leadership of a local MSK network maintaining effective relations with other health service providers in relation to pathway improvements, education and support as required to the benefit of patients, primary care referrers and the commissioners in the health and social care system.

5.1.1 The Service should:

- Offer advice and guidance to referrers
- Optimise functional physical abilities by providing timely access to assessment (incl. diagnostics) and treatment pathways that are evidence based
- Embrace principles of shared-decision making to attain personalised quality of life for those patients with MSK symptoms
- Lead the development of clear, evidence based community pathways of care for both complex and non-complex MSK presentations
- Provide an integrated MSK pathway that will ensure appropriate access for patients and actively manage the demand for secondary care referrals
- Ensure evidence based training and education is delivered to General Practice via Primary Care Network (PCN) arrangements
- Reduce inequalities and improve access to services, enabling those with physical, sensory or learning disabilities and those who do not speak or read English, to have equal access to information and support / services available to manage their condition
- Provide a cost-effective service that does not compromise patients' needs, maximises value for money and remains within the allotted budget aligned to performance indicators (activity based moving to outcome based), efficiency targets and financial outcomes

5.1.2 The service should provide:

- A single point of access for all electronic referrals resulting in rapid access and streamlined care for patients with MSK problems
- A seamless transfer of care and rehabilitation which is co-ordinated and managed in line with best practice guidance
- Co-ordinated and integrated episodes of care across the MSK pathway, that include (depending on locality):
- MSK assessment and treatment, including First Contact Practitioners
- Onward referral to Orthopaedics, working towards agreed secondary care protocol for direct listing for surgery where clinically appropriate (although the operating surgeon still needs to see, assess, discuss options and consent the patient prior to the date of the surgery)
- Physiotherapy and Podiatry services
- Physiotherapy self-referral
- A referral "triage" process, **by senior and experienced clinicians**, (which may include a telephone triage service), with clinical input, moving towards electronic triage
- Evidence based quality of life and symptom profile questionnaires both pre and post intervention
- Pathways and interventions compliant with national evidence based guidelines
- Face-to-face holistic assessments with relevant investigations and diagnostics
- Operate to the principles of shared decision-making, using standardised support tools and decision aids
- Provide patient information leaflets, relevant websites, electronic guidance, lifestyle support and information on national and local support groups including:
- Information for patients on how they can feedback or complain about the care they receive, and make suggestions for improvements
- Information for patients on how to manage common MSK symptoms
- Information for patients on MSK conditions such as osteoarthritis including an explanation of the disease to help them understand their condition
- Information for patients about their current MSK-related medication and available treatments, including side effects and the importance of compliance
- Rapid access (including outside standard working hours) to advice and appropriate treatments for patients experiencing flare up of chronic conditions
- General wellbeing information such as healthy lifestyle, weight loss and smoking cessation

- Signposting to local and national resources including voluntary organisations
- Information for patients on the benefit of Exercise for their condition (such as *Moving Medicine*)
- Promote and support patient self-management - GPs and patients to have access to an MSK digital platform of self-help for patients and an aid for practitioners to avoid unnecessary referrals – *but not to be used as a substitute for those that need face-to-face assessment*
- Provision of education, support and advice for General Practitioners, Therapists and Integrated Care Team Staff including access to guidelines and referral protocols
- Relevant signposting and onward transit of referral and accompanying patient clinical information to other services by the most timely, efficient and effective medium available including use of National Electronic Referral System (ERS). Examples include:
    - Making urgent onward referrals to specialist or secondary care, in line with agreed pathways, where a patient presents with symptoms or conditions meriting consultant specialist opinion
    - Making routine onward referrals to specialist or secondary care, in line with agreed pathways, where following assessment and conservative treatments, a specialist intervention or surgical procedure may be an appropriate next step for the patient
- Seamless system for referrals throughout the different elements of the MSK pathway e.g. physiotherapy, podiatry

Service Objectives:

- Deliver a high quality, cost effective, clinically led, service
- Treat patients at the most appropriate location that is convenient and relative to their needs and preferably as close as possible to the patient's home
- Demonstrate a focus on prevention, including utilisation of "making every contact count"
- Deliver self-management interventions as standard, with well-developed patient decision making materials and media
- Constitute a multi-disciplinary specialist team, lead by an SEM/MSK Consultant and including but not limited to specialist doctors in MSK, extended scope physiotherapists, podiatrists, occupational therapists, chiropractors and patient 'choice' / administration coordinators who are appropriately trained and competent
- Plan, implement and evaluate evidence based care pathways according to individual need; taking into account the patient's personal preferences and are holistic, including psychological factors
- Provide the patient and referrer with an accurate assessment/diagnosis of their MSK condition, with emphasis on patient educational jargon-free information to promote independence and assist patients in the management of their own condition
- Undertake timely access to diagnostic tests as clinically appropriate in line with NICE guidelines and locally agreed pathways
- Enhance the management of MSK patients within the community and actively manage a reduction in demand for secondary care services by ensuring patients have speedy access to clinically appropriate treatment
- Develop agreed models of care and pathways with the commissioner for common MSK conditions with appropriate specialist input in a primary care setting that benefits patient experience
- Closer working with Primary Care Networks providing meaningful support, advice and feedback to referring clinicians resulting in the continuous improvement in the appropriateness of referrals
- Increased use of Patient Activation Measures (PAM) and other patient directed health questionnaires e.g. EQ5D to support patient self-management and ownership of their condition
- The service should be provided by clinicians of all backgrounds, treating every patient with dignity and respect. Chaperones will be offered when required. Patients and their supporters should also show respect to the clinical and administrative staff
- Ensure that services are delivered to meet the specific needs of people with learning disabilities or mental illness so they receive equitable access to services and treatment.
- Provide advice and support to carers as appropriate
- Incorporate service user views and opinions in developing integrated services that best suit user needs
- Clinical and administrative staff to be trained to appropriate level in terms of safeguarding adults and young people

5.2.1 Education and advice

- In addition to primary care network based meetings mentioned above, the service should work collaboratively with other services, organisations and professionals in achieving targets identified in line with local and national good practice and performance
- Provide access to interpretation services to facilitate communication with ethnic minority groups as necessary
- Advice and guidance to referrers with the aim of avoiding outpatient appointments

5.2.2 Communication and Interface with Primary, Secondary and Integrated Care Service Providers

The service should inform the patient's GP of acceptance into the service and provide a summary of the proposed treatment plan following the first holistic assessment appointment. Similarly, the service should write a discharge letter to the GP confirming discharge from the service with a summary of treatment undertaken and outcomes achieved (functional ability / symptom resolution / pain relief etc.) together with details of any proposed lifestyle modification or self-management advice. The discharge letter should be sent to GP within an appropriately agreed timeframe.

The provider must ensure that all appropriate test results and information collected by the service are passed on to secondary care when an onward referral is made (where possible via electronic transfer), in accordance with Information Governance rules. Once the referral has been accepted by secondary care, a discharge letter should be sent to the patient's GP confirming the onward referral and discharge from the service.

5.2.3 Population covered

The service should provide services for <age limits to be agreed locally> with either known or suspected musculoskeletal symptoms/conditions and who are registered with a GP.

5.3.1 Acceptance of Referrals <may vary across localities and local need>

Referrals should be accepted into this service for suspected or known musculoskeletal conditions and symptoms (in patients that are <age limits to be agreed locally> of age and over) including (but not limited to):

- Soft tissue injuries
- Osteoarthritis (OA)
- Non-inflammatory arthritis, including Gout, but NOT for known or suspected inflammatory arthritis.
- Fibromyalgia
- Chronic non-complex Pain provided it is musculoskeletal in origin, and will have access to IAPT/counseling and some resources to help support and manage patients with persistent pain, but will refer on to Secondary Care Pain Clinic if deemed too complex. <to be agreed locally>
- Chronic Fatigue
- Secondary Care Consultant referrals e.g. ED/Rheumatology/Orthopaedics/Pain for patients registered with a GP in the local defined area

An Electronic referral template (to ensure the provision of requisite information), should be completed in full including information on weight/BMI, smoking, significant co-morbidities and any special patient needs.

FCPs or GPs should initiate appropriate Xrays, blood tests and other appropriate in primary care prior to referral in order to make triage more effective and reduce patient waiting time.

The provider should work with commissioners to monitor adherence to the local/national policy and procedure for restricted treatment and procedures. If directly listed for surgery (although the operating surgeon still needs to see, assess, discuss options and consent the patient prior to the date of the surgery), any prior approval forms for surgery must be completed before referral onto secondary care.

Red Flags

If triage suggests a red flag, the referral should be passed to the appropriate department within secondary care within 3 working days.

If a clinical assessment or radiology or pathology test or report suggests a malignancy, new unstable fracture, or other pathology requiring urgent care outside the MSK service.

- The patient should be referred to secondary care urgently. Ideally this referral should be made by the clinician who assessed the patient; if that is not possible another senior member of staff should make the referral
- Ideally, the clinician who saw the patient should notify the patient of the new referral and the reason for it
- The GP should be notified of the new urgent referral

5.3.2 Acceptance into the Service and MSK Hub first appointment

- If accepted into the service following triage, the patient should be sent evidence-based symptom profile and quality of life questionnaires to complete and bring to their appointment. Patients should also be asked to provide all details of current and previous medication
- Referrals should be (electronically) triaged by the senior clinical team within 2 working days <to be agreed locally> of receipt and a clinical decision made on the next stage of the pathway
- The wait for an initial clinical assessment should not exceed 20 (twenty) working days from the date of the referral for routine appointments and 10 (ten) working days from the date of referral for urgent appointments <to be agreed locally>
- Appropriately trained and qualified clinicians, including physiotherapists, podiatrists, occupational therapists, specialist MSK doctors and other AHPs, should undertake assessments

5.3.3 Acceptance into the Service for Physiotherapy Appointments

A physiotherapy service incorporating a package of care including:

- An initial assessment
- Support to patients for self-care
- Follow up appointments as appropriate to clinical need

Initial clinical assessment for physiotherapy
An initial physiotherapy assessment appointment is required for every patient. During this appointment the provider must confirm whether it is an appropriate referral and that the patient would benefit from physiotherapeutic intervention. For accepted referrals, it is expected that treatment should normally commence during this first assessment appointment and a patient management plan should be agreed.

This first appointment must include the identification of any red flags (indicators in the history or examination suggestive of serious underlying pathology). Where a red flag is found then the physiotherapy provider should make use of the agreed care pathway to make onward referral within the required timeframe. The patient and original referrer should be advised accordingly.

The first appointment must also include the identification of any yellow flags (indicators in the history or examination of psychosocial (surmountable) obstacles to recovery). The provider must be able to identify these obstacles and be able to work with patients towards overcoming them.

For all accepted referrals that have been seen within the MSK hub, a Patient Reported Outcome Measure (PROM) pre-treatment questionnaire will have been undertaken during the triage/assessment and copied to the Physiotherapy provider. For referrals that are triaged directly to Physiotherapy a PROM will need to be completed by the physiotherapy provider.

If a referral is not deemed appropriate for physiotherapy intervention then a conversation with the provider of the MSK triage/assessment will be undertaken by the physiotherapist to discuss the reasons and jointly agree the next course of action. The patient should be informed directly of any change to the pathway and this will not result in a delay to their care being received.

Follow up appointments
For all referrals that are accepted, a package of care should be provided consisting of the necessary treatment required to meet the individual clinical needs of the patient. Treatment recommended as part of

the package of the assessment must have robust, evaluated clinical evidence. A decision should be made for the requirement for follow-up appointments to be offered, after which the patient is discharged, if deemed appropriate, with advice for self-management and or home exercises. It may be acceptable for some patients to have several review appointments if clinically appropriate. Appropriate measures should be undertaken to maintain clinical governance with regular clinical supervision and review of treatment plans. Once it has been identified by a senior clinician, a summary of the reasons additional treatment is required should be emailed to the GP. Response will be within 7 days.

These treatments may include but should not be limited to:

- Advice and education on long term condition management
- Self-care advice and literature
- Acupuncture
- Manual therapy
- Soft tissue mobilisation
- Electrotherapy
- Exercise programmes

Access to therapy services

- On referral to the physiotherapy / podiatry service, it should be assumed that the patient is aware of the referral and the reason for referral
- The patient should be prepared to commit to the physiotherapy /podiatry assessment and make every reasonable effort to attend appointment
- Appointments should be made at a suitable time for the patient, where possible, allowing for operational demands of the service
- Should a patient not attend their first new patient appointment, without giving any prior warning, this will be considered as a DNA
- The patient will then be offered one further new appointment. Should the patient DNA this second appointment, they will be discharged back to the MSK service with a copy of the discharge letter to the patients GP
- If a patient is UTA (unable to attend) on two consecutive occasions they will also be discharged. This could be as a new patient or during a course of treatment

5.3.4. Acceptance into the service for Podiatry Appointments

The service will provide:

- An initial assessment
- Support to patients for self-care
- Follow up appointments (a maximum number of follow ups <to be agreed locally>)

Initial Clinical Assessment and Treatment for Podiatry

The provider is required to undertake an initial podiatry assessment appointment for all patients. During this appointment the provider must confirm whether it is an appropriate referral and that the patient would benefit from their podiatry package. For accepted referrals, it is expected that treatment should normally commence during the first assessment appointment and a patient management plan should be agreed.

The first appointment must include the identification of any red flags (indicators in the history or examination suggestive of serious underlying pathology) which should be managed as per local pathway.

The initial appointment must also include the identification of any yellow flags (indicators in the history or examination of bio-psychosocial obstacles to recovery). The Provider must be able to identify these obstacles and be able to work with patients towards overcoming them.

For all accepted referrals that have been seen within the MSK hub, a Patient Reported Outcome Measure (PROM) pre-treatment questionnaire will have been undertaken during the triage/assessment and copied to the Podiatry provider. For referrals that are paper triaged directly to Podiatry a PROM will need to be completed by the Podiatry provider.

For all accepted referrals the provider should notify the MSK Provider and GP and provide a copy of the patient's agreed intended care package on discharge or onward referral.

If a referral is not deemed appropriate for podiatry intervention then a conversation with the provider of the MSK triage/assessment will be undertaken by the podiatrist to discuss the reasons and jointly agree the next course of action. The patient will be informed directly of any change to the pathway and this will not result in a delay to their care being received.

Treatments may include but should not be limited to:

- Physical therapies (low level light therapy and acupuncture)
- 'Off the shelf' orthotic management
- Injections (Morton's neuroma, metatarsalgia and arthritic foot joints)
- Other treatments within a Podiatric scope of Practice

Patients may be referred with any musculoskeletal conditions to include, but not limited to:

- Arthritis
- Heel pain
- Achilles tendonitis
- Peroneal tendonopathy
- Knee, leg, foot, ankle pain
- Subtalar joint pain.

5.3.5 Acceptance into the service for First Contact Practitioner (FCP) Appointments

Where GP recruitment is a problem First Contact Practitioner (FCP) physiotherapists working in Primary Care can supplement GP capacity. The FCPs should be fully integrated into the Community MSK service and ideally working in both as community APP and primary care FCP's, contributing to continuity in the MSK pathway.

Suitable patients contacting general practice complaining of MSK problems can be booked directly into an MSK FCP appointment within general practice, without the need to see a GP first.

A 20 minute <to be agreed locally> appointment will be offered, where the patient will be assessed by an appropriately trained specialist MSK physiotherapist, working at a minimum to the competencies within the Musculoskeletal Core Capabilities Framework

Following assessment the FCP should:

- Provide advice and guidance to support management/treatment of the presenting condition utilising supported self-help programmes as appropriate
- A follow-up appointment may be offered if deemed appropriate
- If the patient requires further intervention the therapist should arrange onward referral to the MSK hub
    - If referral to secondary care specialist services is required, including diagnostics, the FCP should arrange this via the patients GP

FCPs working with primary care should have access to primary care computer systems or alternatively use a system that can easily forward an electronic patient record to GPs.

FCPs or GPs should initiate appropriate Xrays and blood tests in primary care prior to referral onwards.

FCPs will be expected to work towards competencies that enable qualified access to MRI, CT or diagnostic ultrasound and have agreed protocols in place with the diagnostic provider for accessing these services.

Referral Classifications

'Urgent': Patient referral is considered urgent if one or more of the following apply:

- Patients in severe pain, or pain unable to be controlled by regular analgesia
- Severe sleep disturbance due to condition
- Clinical condition likely to significantly and quickly deteriorate without intervention
- Severe impairment of activities of daily living, especially absence from work
- Deteriorating neurological states

'Routine': All patient referrals that are not categorised as urgent, for example:

- Patient with intermittent pain
- Patient has a mild to moderate reduction in functional ability
- Mild to moderate impairment of activities of daily living
- Patient's condition has the potential for improvement with intervention

5.3.6 Exclusion Criteria <to be agreed locally>

The service should adhere to the following exclusion criteria:

- Self-referrals - *except for FCP appointments following locally developed protocols*
- Children up to their 16th birthday will be treated via the separately commissioned Paediatric MSK or Orthopaedic Services <To be agreed locally>
- Those requiring emergency treatment, red flag symptoms, suspected serious pathology
- Presenting condition is known not to be primarily neuro-musculoskeletal in origin
- Widespread neurological symptoms with or without upper motor neurone signs
- Patients who have a neurological condition which requires physiotherapy
- An infection or other active pathology which would interfere with assessment or treatment process
- Systemically unwell (fever, malaise, rigors)
- Known or suspected metastatic Cancer or palliative patients
- Cancer patients with a spinal fracture under active treatment or monitoring, or palliative patients
- Patients with a spinal fracture excluding compression fractures
- Restricted treatment and procedures as per the COMMISSIONERS policy
- Domiciliary service to housebound patients who cannot travel by private or public transport (To enable greater access for immobile or patients without means to travel the service will liaise with non-emergency patient transport service (PTS). Patients meeting the eligibility criteria will be confirmed and arranged by the GP practice. Subsequent follow up appointments will be arranged by the service provider – in accordance with PTS guidance)
- Active inflammatory rheumatological disease except for assessment of its orthopaedic impact
- Women who are over 35 weeks pregnant

5.3.7 Whole system relationships and Interdependence with other services/providers

- The service provider should build positive working relationships with the other healthcare providers in the locality. In accordance with agreed commissioning protocols the service provider can refer patients directly to appropriate secondary care departments, maximising the efficiency of a pathway served by more than one provider
- Whole system partners will include:
    - Community Services
    - NHS Secondary Care Acute Trusts
    - Patient Forums
    - GP Practices
    - Commissioners
    - Independent Providers

5.3.8 Discharge planning and criteria

- Once a patient has achieved their agreed goals or has an appropriate ongoing management plan in place, patients should be discharged from the service
- GPs should be informed once a patient has been discharged from the Service
- The GP should be provided with a written summary of assessments, diagnostics, and future / ongoing management plans within standard NHS timescales
- On discharge from the service, the provider must ensure that the patient has the service contact information and that both the patient and their GP are aware that entry back into the service is the responsibility of the patients GP, unless explicit patient initiated 'open' appointment has been arranged as part of the future / ongoing management plan
- On discharge for onward care to other appropriate providers within the 18 week referral to treatment pathway, prompt and complete information should be supplied

6. Location of provider premises

6.1 The service should have a central booking, management and administrative function for all satellite clinics (FCPs working within a primary care setting could be booked via GP receptions). The centralised booking function should act as a single point of access for all referrals.

The provider should be required to ensure there is fair and equitable access to clinics across all localities for the local population, to be defined in conjunction with Commissioners.

Commissioners have a key aim to deliver care closer to home. Therefore clinics must be provided in geographically convenient, easily accessible locations which:

- Comply with health and safety regulations
- Have disabled access
- Have appropriate waiting and treatment areas, amenable to physical examination, treatment and exercise
- Are appropriately furnished and equipped with necessary equipment
- Meet cleanliness and hygiene standards
- Are easily accessible via public transport
- Have suitable car parking available for patients and their carers

The services may be located in the providers own premises, suitable premises available for rental locally either through healthcare organisations or other premises or an appropriate mobile facility. Where providers operate clinics in other locations which might be more convenient to a patient – i.e. nearer to their home or work or where there is a shorter waiting time, alternative locations should continue to be offered.

6.2 Patients with learning disabilities

Attention must be given to delivery of care for patients with learning disabilities, ensuring the environment in which care is delivered is appropriate to support them and meet their needs to achieve the best outcomes.

6.3 Day and Hours of Operation <to be agreed locally>

The normal working hours for the service are expected to operate every week of the year unless agreed in advance with the Commissioner. The expectation is for the hub to operate Monday to Friday, excluding Bank Holidays but including some Saturday mornings (allowing for a percentage of clinics to be provided outside of 9am – 5pm working hours). The expectation for the FCP element of the service is that this operates in line with GP extended hours of provision i.e. until 8pm on weekdays, on rotation within PCNs, and Saturday mornings until 12.30pm.

Although the service is not for emergencies, some flexibility should be allowed to accommodate more urgent referrals and to cope with any fluctuations in demand.

Wherever possible care should be delivered at a Primary Care Network level.

7. Applicable service standards

7.1 Applicable national standards (e.g. NICE).

- The service provider must comply with all relevant policy and procedure as contained in the NHS Standard Contract
- Lower Back pain and Sciatica in the over 16's: NICE Quality Standard QS155 – July 2017
- Osteoarthritis: Care and Management – CG177 – February 2014
- Rheumatoid Arthritis in Adults: Management (NG100)
- Musculoskeletal Conditions and Multimorbidity – Arthritis Research UK – 2013

7.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- Department of Health - National Paperless Strategy 2018

7.3 Applicable local standards

The service provider must comply with all relevant policy and procedures as contained in the following documents:

- Commissioner's Policy on Restricted Treatments and Procedures
- Compliance with the commissioner's Serious Incident Reporting policy
- Be registered with the Care Quality Commission (CQC)
- Maintain complaints procedure(s) compliant with current NHS regulations, including any NHS complaints Regulations in force
- Supply details relating to that complaints procedure to patients and their families as may reasonably be required
- Follow the best practice guidance for infection control
- Ensure awareness of all employees to policies and procedures including Health and Safety Legislation and ensure that they are adhered to at all times, including:
    - Standing Financial Instructions
    - Latest guidelines
    - Standing Orders
    - Emergency procedures
    - Dealing with spillages
    - The using of Latex gloves
    - Dealing with clinical waste and sharps
    - Infection control
    - Management of needle stick injury
    - Have an equivalent policy for the following:
    - Accessible Information Standard
    - Business Continuity
    - Chaperone
    - Clinical and Professional Supervision
    - Clinical Waste Management
    - Complaints and Concerns
    - Consent to Treatment
    - Deprivation of Liberty Safeguards (DoLS)
    - Dignity and Respect
    - Duty of Candour
    - Environment
    - Equality and Diversity
    - Equipment maintenance and Safety Checks
    - Falls Management Protocol
    - Hospitality and Gifts (could be framed with Fraud Awareness or Conflicts of Interest Policy)
    - Harassment and Bullying
    - Human Resources including Recruitment and Training (employment checks i.e. DBS, Professional Registration/Immunisations/Hep B status etc)
    - Incident Reporting and Investigation
    - Information Governance and Confidentiality
    - Interoperability (Digital)
    - Lone Worker
    - Medication Administration
    - Mental Capacity and Best Interests
    - Medical Emergency Management
    - Nutrition and Hydration

- Patient Group Directives (PGD)
- Prescribing
- Quality Assurance
- Record Keeping
- Tissue Viability (this should encompass pressure ulcers i.e. reporting of)

If a non NHS Provider, the provider must hold an information sharing agreement as per Caldicott principles, namely an information governance statement of compliance which has been assured by external assessors and is accessible to the public.

- The provider must ensure systems and processes are in place to ensure continuity of care based on clinician, information provided and treatment
- The provider must have an appropriate clinical risk management system in place
- The provider must ensure that a senior lead clinician with managerial responsibility takes the lead for the day to day running of the service
- The Provider must convey all/any suspicious findings to the patient's GP within 3 working days, even if an onward referral to secondary care has been made. Should urgent input be required by the patient's GP for any reason, this must be communicated by phone indicating that urgent / immediate action is required by the named GP
- Review appointments must be arranged by the provider at a mutually convenient time and place for the patient

7.4 The service must:

- Provide fully skilled and trained, appropriately qualified personnel and provide a competency based training package to ensure staff have the required knowledge and skills to deliver safe and effective practice
- Identify a governance lead, with responsibility for National Patient Safety Agency (NPSA) alerts. Risk management must include the reporting of all incidents to the NPSA anonymously and have a broadcasting system to all health professionals within the service regarding NPSA, Medical Device Alerts (MDA) and medication alerts. The Provider must demonstrate the evidence on how this mechanism functions. A governance framework should stipulate that operational management, resources and identify staff numbers, title and WTE. Information governance toolkit must demonstrate level 2 and above
- Support continuing professional development for all staff with clinical leadership and supervision. All clinicians, where appropriate to attend regular meetings including MDT for peer support. Clinicians must be encouraged to engage with any relevant networks across the health economy and should be multi professional
- The provider must ensure the safe delivery of clinical services providing a leadership structure and governance that is fit for purpose. The provider will be expected to promote a culture of learning within its organisation ensuring that the following are provided:
    - Clinical Leadership
    - Integrated governance
    - Clinical safety and medical emergencies
    - Incident reporting
- Provide information and advice leaflets, digital tools and a website for patients. Other multi-media formats (including Braille, large print), and must be made available if the need has been identified. Information should be age and language appropriate
- Facilitate a group approach and expert patient involvement and support carers where required.
- Be responsive to people with learning disabilities, mental health problems and those from ethnic minority groups. The provider must ensure that all staff undertakes mental capacity training, equality and diversity training and conflict resolution training
- The provider must ensure that the best interests of people are maintained through constant evaluation with a system for continuous improvement
- Provide a mechanism for collecting patient feedback and responding appropriately

7.5 The provider must demonstrate it meets patient and public expectations of

- Empathetic and compassionate care provision
- Staff who have specialist skills and knowledge with experience and undergo regular training
- A holistic approach, understanding and supporting the impacts of the condition on the patient's quality of life
- Encouraging self-care and empowering patients and carers to be proactive and involved in the management of the condition

7.6 The provider must ensure that the following levels of supervision are provided to the clinical staff team

- Management supervision
- Clinical supervision
- Safeguarding supervision (safeguarding issues to be referred to named nurses within the provider's safeguarding team)

8. Applicable Quality Requirements and CQUIN Goals

8.1 The provider will be expected to participate in an annual audit and any other initiatives as measures of performance.

8.1.1 The provider must provide:

- A copy of their registration document for CQC
- Evidence of practitioners being trained to accredited standards and maintaining competency utilising a competency framework and demonstrated through personal development plans and annual review
- Evidence of staff having up to date training with regards to safeguarding adults and children and basic life support
- Number of complaints and compliments received, analysis of key themes and associated improvement plans
- A copy of complaints and compliments on request
- Significant events and outcomes Audit undertaken on unsuccessful treatment and patient improvement and embedding of key learning

8.1.2 The provider will develop and fully embed a process of continuous improvement engaging with service users, the public and referrers (as a minimum).

8.1.3 Service user feedback

- Offer all users of the service the opportunity to participate in a standardised patient experience survey (in multiple formats) to highlight strengths and weaknesses of service provision from a service user perspective. This should include a measure of the patients perceived self-efficacy to manage their condition
- Gather baseline patient reported outcome measure data to facilitate an evaluation of eventual outcomes for the patient
- Review the outcomes of this survey bi-annually to identify areas of service development and improvements and share the report with commissioners
- Agree (with commissioners) and implement improvements where required and monitor their effectiveness

8.1.4 Referrer feedback

- Offer all referrers into the service the opportunity to participate in a standardised experience survey (in multiple formats) to highlight strengths and weaknesses of service provision from a referrer perspective
- Review the outcomes of this survey biannually to identify areas of service development and improvements and share the report with the commissioners

- Agree (with COMMISSIONERS) and implement improvements where required and monitor their effectiveness
- Participate in regular service monitoring on an ongoing basis, with formal review in September each year

9. Key Performance Indicators (Annex A) <to be agreed locally>

The commissioners will monitor and evaluate the service on a regular basis through a series of methods including but not limited to service audits, service reviews, financial audit and patient feedback.

The commissioners will require the provider(s) to work with them to manage demand, reduce waiting times for patients and improve outcomes on the NHS Standard Performance Targets including the 18 week target.

The provider(s) will report achievement against monthly/quarterly performance activity indicators. This will be provided at a total provider level, including any work undertaken by any subcontractors. This will be used to further develop relevant and appropriate indicators and the movement to an outcome based specification. It will also be shared with referring clinicians in order to further inform their referral decisions.

Annex A

Ref	Operational Standards	Threshold Agreed	Method of Measurement	Consequence of Breach	Monthly or Annual Application of Consequence
FCP <If appropriate>– initial data collection with further dataset to be jointly agreed by provider/CCG following development of service/roles					
FCP 1	Total No of patients seen by First Contact Practitioner (FCP)	N/A	Monthly		
FCP 2	No of patients seen by FCP within 10 working days of contacting surgery	80%	Monthly		
FCP 3	No of patients seen by FCP within 20 working days of contacting surgery	100%	Monthly		
FCP 4	No of patients referred onto MSK hub for further review following FCP assessment	N/A	Monthly		
FCP 5	No of patients discharged (requiring no further input) following FCP assessment	N/A	Monthly		
FCP 6	No of patients requiring diagnostic intervention and modality – x-ray/US/MRI etc	To baseline year 1	Monthly		
MSK Pathway including FCP					
MSK 1	Total No of referrals received broken down by referral source – FCP/GP/Secondary Care	N/A	Monthly		

MSK 2	No & percentage of urgent referrals paper triaged within 2 working days	80%	Monthly		
MSK 3	No & percentage of routine referrals paper triaged within 5 working days	80%	Monthly		
MSK 4	No & percentage of referrals paper triaged and sent back to referrer as inappropriate/incomplete	To baseline year 1	Monthly		
MSK 5	No & percentage of urgent referrals seen by MSK hub within 10 working days of referral	80%	Monthly		
MSK 6	No & percentage of routine referrals seen within MSK hub within 20 working days of referral	80%	Monthly		
MSK 7	No & percentage of urgent referrals seen within 10 working days of referral from MSK Hub to Physio/Podiatry split by specialty (Physio/ Podiatry)	80%	Monthly		
MSK 8	No & percentage of routine referrals seen within 20 working days of referral from MSK Hub to Physio/Podiatry split by specialty (Physio/ Podiatry)	80%	Monthly		
MSK 9	Total No of New appointments broken down by service modality – MSK Hub/Physiotherapy & site –	N/A	Monthly		

	upper limb/lower limb/spine/ Podiatry				
MSK 10	Number of New appointments split by delivery method – Face to face/Non Face to Face (F2F/NF2F)		Monthly		
MSK 11	Total No of Follow up appointments broken down by service modality – MSK Hub/Physiotherapy and site – upper limb/lower limb/spine/Podiatry	N/A	Monthly		
MSK 12	Number of Follow up appointments split by delivery method – Face to face/Non Face to Face (F2F/NF2F)		Monthly		
MSK 13	Total No requiring onward referral including destination/specialty following: • Paper Triage By modality after: • MSK hub/ Physiotherapy/ Podiatry intervention	To baseline year 1	Monthly		
MSK 14	Number and percentage of onward referrals from MSK to Secondary Care for elective lower limb opinion.	To baseline year 1	Quarterly		
MSK 15	Number and percentage of onward referrals from MSK to Secondary Care for	To baseline year 1	Quarterly		

	elective upper limb opinion				
MSK 16	Number and percentage of onward referrals from MSK to Secondary Care for elective spinal opinion	To baseline year 1	Quarterly		
MSK 17	No of DNAs broken down in News/Fup and by modality: FCP/ MSK hub/ Physiotherapy/Podiatry	<7.5%	Monthly		
MSK 18	No of cancellations split into provider/patient broken down to News/Fup and by modality: FCP/MSK hub/ Physiotherapy/Podiatry	<7.5%	Monthly		
MSK 19	% of Discharge summaries sent to referrer within 5 days of treatment ending broken down into modality MSK/Physiotherapy/Podiatry	95%	Monthly		
MSK 20	Percentage of patients still on RTT pathway who are referred to secondary care within 9 weeks to be no more than 85%	Numerator – No of patients still on RTT pathway referred to secondary care within 9/52 Denominator – All patients still on RTT pathway referred to secondary care	Monthly		
MSK 21	Percentage of red flag referrals triaged and sent onto secondary care within 24 hours	100%	Monthly		
MSK 22	No of diagnostics by type (e.g. x ray, MRI, CT, EMG, Ultrasound etc by site)	Collect baseline year 1	Monthly		

MSK 23	Number of extended treatment requests	No more than 60 per year	Quarterly		
MSK 24	No of patients offered use of digital platform/app to support self management	Collect baseline year 1	Quarterly		
MSK 25	No of patients demonstrating compliance with use of digital platform/app management aids	Collect baseline year 1	Quarterly		
Quality					
Q 1	No of patients completing pre-assessment PROM e.g. EQ5D, MSK-HQ, Short-form IPAQ or Kaiser-permanente 2 “vital signs” questions	100%	Monthly		
Q 2	No of patients completing post-treatment PROM e.g. EQ5D, MSK-HQ, Short-form IPAQ or Kaiser-permanente 2 “vital signs” questions	100%	Monthly		
Q 3	Patient outcome (improvement in Health & Wellbeing, e.g. independence/ability to function) satisfaction scores following baseline period	85% reported improvement/satisfaction	PROMS – completion of a validated PROMS before and after treatment eg EQ5D - quarterly		
Q 4	Patients should report overall satisfaction with the service	95%	Audit of surveys/Friends and Family Survey - Quarterly		
Q 5	Annual service improvement review with commissioners to inform service developments and key areas of performance	Annually	Audit document		

Q 6	Referrer satisfaction surveys	95% reported satisfaction	Audit of sample of surveys - Quarterly		
Q 7	Numbers of compliments and complaints /SIRI and response times	N/A	Provider to measure and report to Commissioner - Quarterly		
Q 8	Personalised care planning	100% patients have a documented treatment plan and agreed personalised goals	Audit document - Quarterly		