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SCHEDULE 2 – THE SERVICES

• Service Specifications

Service Specification No.	
Service	Integrated Musculo- skeletal, Pain and Rheumatology service. (IMPReS)
Commissioner Lead	East Lancashire CCG
Provider Lead	ELHT, Tracy McGlone , Dr Tony Mitchell and Jo Lishman
Period	April 2015 to March 2017
Date of Review	April 2016

1. Population Needs

• National/local context and evidence base

It is widely recognised that Musculoskeletal (MSK) conditions are common and a major cause of ill-health, pain and disability. They are the most common reason for repeat consultations with a GP, making up 30% of primary care consultations[1]

Evidence for effective interventions is widely documented, and included within, for example NICE guidance, Musculoskeletal Services Framework, Clinical Standards Advisory Group (CSAG) guidelines on the management of Back pain, British Society of Rheumatology Journal, the BMJ and British Pain Society publications

There is also good evidence from England that a wide range of clinical activity can be safely and effectively provided outside the acute hospital. The Department of Health supports the development of access to specialist community based services[2]

The model for interface service provision is outlined within the best practice content of the Musculoskeletal Services Framework (DH 2006) and within The Focus on MSK Interface Services (Institute for Innovation and Improvement 2009)

Evidence is documented nationally that up to 70% of all secondary care orthopaedic referrals may be inappropriate and that MSK triage services reduce secondary care orthopaedic referrals by as much as 65%

Previous models of MSK service exist for the population of East Lancashire, within hospital based Orthopaedics, Rheumatology, Chronic pain and community based Pennine-Lancashire Integrated Musculoskeletal Service (PLIMS). Each has experienced, expert staff and delivers an excellent service in its own right, however, across services each has its own point of access, with variance of waiting times and service models,

[1] Department of Health (2006) The Musculoskeletal Services Framework - A joint responsibility: doing it differently. Department of Health, London.
[2] Department of Health (2006) Our Health, Our Care, Our Say: a new direction for community services. Department of Health London.

leading to potential fragmented care, dis-jointed pathways, variance of skill and knowledge, less than optimal outcomes & experience for the service user, care in a hospital environment, when it may not be clinically necessary and longer patient journeys than may be necessary.

Secondary care orthopaedic service for East Lancashire Hospitals Trust experience unprecedented demand that exceeds capacity, yet, with reported MSK care being provided in a hospital setting, for some patients, who could be treated in the community.

The implementation of a comprehensive multi-disciplinary community based integrated MSK service, bringing together Rheumatology, pain management and MSK services will effectively and safely manage MSK conditions that do not require orthopaedic intervention at secondary care level, will enable improved patient flow through evidence based integrated pathways, will deliver training and education to GP practices, and will provide self-management programmes, thereby, support the management of increasing demand for secondary care services. This will work within the 18 week referral to treatment (18 week RTT) and ensure effective use of NHS resources.

This specification is underpinned by the following guidance; relating to community based MSK services:

- Department of Health (2005) Care Closer to Home; Creating a Patient led NHS;
- Department of Health (2006) Our Health, Our Care, Our Say: a new direction of
- community services
- Department of Health (2006) The Musculoskeletal Services Framework - A joint responsibility: doing it differently
- Institute for Innovation and Improvement (2009) Focus on MSK Interface Services

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions** **2** Health-related quality of life for people with long-term conditions **2.1:** Proportion of people feeling supported to manage their condition **2.2** Employment of people with long-term conditions. **2.3.i** Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) **2.4** Health-related quality of life for carers	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury** **3a** Emergency admissions for acute conditions that should not usually require hospital admission	✓

	3b Emergency readmissions within 30 days of discharge from hospital	
Domain 4	**Ensuring people have a positive experience of care** **4.1:** Patient experience of outpatient services **4.8:** Children and young people's experience of healthcare **4.9:** People's experience of integrated care	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm** **5a** Patient safety incidents reported **5b** Safety incidents involving severe harm or death **5.4** Incidence of medication errors causing serious harm	✓

2.2 Local defined outcomes

The Community Integrated MSK Service will be delivered to a high standard, by GPs with Special Interest, Consultant Rheumatologists, Consultants in Pain Management, Specialist Nurses, Extended Scope Practitioners, Clinical Psychologists, Specialist Physiotherapists, Occupational Therapists & Podiatrists, AHPs, nurses and support staff, with strong Clinical leadership and robust governance to ensure that the service is:

- **Safe:** patient safety is enhanced by the use of health care processes, working practices and systemic activities that prevent or reduce the risk of harm to patients
- **Effective:** focused on delivering evidenced based practice, with shared decision making; achieving the best outcomes for patients
- **Standardised:** all services are provided to a consistent standard and format so patients can expect the same quality of care and access to care wherever they are treated
- **Fair:** available to all, taking account of the health needs and culturally diverse population of East Lancashire
- **Personal:** treating all patients with respect and dignity; tailoring care to individual need
- **Efficient:** operating within a culture of continuous quality improvement and delivering value for money
- **Accessible:** short waiting times to first appointment, smooth expedious integrated pathways and choice of appointment across the borough of East Lancashire

The service will demonstrate compliance with Care Quality Commission (CQC) Essential Standards of Quality and Safety 2010 Outcomes

All digital imagery and patient information will be linked appropriately through IM&T governance to the Picture Archive Communication Systems (PACS) and NHS information systems

The service will interpret and implement standards in ways which challenge discrimination, promote equity of access & quality of services, reduce inequalities in health and which respect and protect human rights.

The service will be provided by a team of registered healthcare professionals, with appropriate qualifications and post registration experience, skills and competencies,

ensuring that all staff have the necessary pre-employment checks, including Disclosure and Barring, qualifications, training, experience and references.

The service will be responsible for the measurement and evaluation of all care provided by the MDT; this may be through the use of evidence based projects, research, governance, audit & outcome measure, to influence positive change and development & improvement in service provision.

The service will be responsible for ensuring that the healthcare professionals are supported and complemented by appropriately trained and competent support staff.

The service will ensure that all clinical staff have regular training, professional development & annual appraisal and are familiar with current best practice. All clinical staff will be clinically supervised (including peer review) and training needs will be identified in line with the relevant professional requirements. Staff will be expected to deliver in-service training and education, based on latest clinical evidence, relevant to their clinical role. The service will also accept students, for eg, Medical students on educational placements. This approach will be based on a service training needs analysis and development plan for senior staff, combined CPD sessions and internal support for supervision and staff development.

The service will also provide education and development support to primary care. This will include website, advice line, training for practitioners performing joint injections and locality based protected learning events and educational forums.

The service will operate within robust Governance arrangements; being actively engaged in clinical governance to ensure probity around clinical leadership, clinical and cost effectiveness, health and safety, risk analysis and mitigation of risk, corporate governance, and evidence based practice; underpinned by clinical and performance standards.

The service will adhere to NICE guidance, National standards and clinical priorities.

The service will be responsible for the contracts of employment of all the staff; ensure each work within a full and comprehensive range of policies and procedures.

Clinical and professional leadership will be assured by the service; ensuring consistent delivery of a quality service with excellent outcomes, with particular attention to: recruitment & retention of high calibre staff, range of workforce, wealth of skill mix, team work, training and development, appraisal, assurance of professional standards, appropriate attitudes and behaviour and review of individual professional practice & competence.

The service will work within a culture of continuous improvement; all staff will identify improvement in practice, along with removal of non-value adding activity, supporting the introduction of new systems/procedures/policies/protocols that will benefit patients' experience & outcomes, reduce the risk of harm and increase efficiency.

These standards will be reviewed annually as a minimum, or as directed by NHS regulation to ensure the delivery of safe personal effective care; a quality report will be issued to East Lancashire CCG.

3. Scope

3.1 Aims and objectives of service

Aim

By providing a model of community based, integrated musculoskeletal services, with a single point of access, the aim is to deliver high quality patient-centred care, which is well co-ordinated and tailored to individual need; being locally accessible, equitable and offering value for money.

The service will provide the full range of Integrated Musculoskeletal specialist care (Rheumatology, MSK and Pain management) historically often delivered in a secondary care setting and will only onward refer patients to a secondary care provider should they require highly specialised secondary or tertiary care.

The service will ensure that people with musculoskeletal conditions have access to high quality effective and timely advice, assessment, diagnosis and treatment, appropriate to their condition. The approach is based on shared decision making & care and structured around a smooth patient journey & seamless, evidence-based integrated care pathways.

Through better integration of services and timeliness of treatment, the service aims to reduce the need for hospitalisation and /or hospitals based intervention and provide better care & services to patients and carers alike, in the community where possible and appropriate.

Services will be provided by a range of expert specialist healthcare professionals working across a variety of settings, within Multi-disciplinary teams, enabling patients to access care closer to home, reducing waits and unnecessary visits to hospital, leading to better health outcomes and patient experience.

The model of service will focus on the holistic needs of the service user, through a collective partnership and pro-active MDT approach, to develop an informed activated patient, with greater autonomy and independence to manage their longer term health and well-being but with the ability to recognise symptoms, which may require further specialist advice (e.g. flare of their disease) and to access appropriate advice and care directly

The service will support primary care practitioners and other clinicians in driving up skills and knowledge, in the identification of patients with musculoskeletal conditions and in the continuing care of people with less complex need or during times of stability

Objectives

To provide a single point of access to a rapidly accessible community based integrated service, for people with a musculoskeletal condition, and for those requiring pain management (non-cancer).

To provide specialist assessment, treatment & clinical management, with optimal outcomes and support patients with self-management strategies and lifestyle change, to aid and encourage people living with long-term conditions to make daily decisions that improve health-related behaviours and clinical outcomes; working to promote:

- Effective pain management
- Maximisation of mobility and function
- Quality lifestyle

To improve access and deliver an equitable service, that is culturally sensitive and meets the diverse population health needs of East Lancashire

To focus on the patient, listening and taking note of the problems as they see them,

providing agreed care plans to meet individual needs and goals, managing a patient's health and well-being within a community (care closer to home) setting; avoiding unnecessary hospital based intervention

To provide timely access to a range of diagnostics, to determine diagnosis, facilitate shared decision making with each individual patient and initiate earlier appropriate treatment

To provide holistic care and agreed clinical management plans, delivered within the community, designed around a multi-disciplinary co-located approach that meets the individual's physical, psychological, emotional and social needs by offering appropriate assessment and treatment and/or signposting to appropriate services, delivering this with excellent patient reported experience and optimal patient reported outcomes.

To deliver agreed packages of care that moves the patient swiftly along an integrated evidence-based pathway and ensures each patient is seen by the right person, at the right time, in the right place, in the right order, each time and every time

To provide early access to individualised care, which support a faster return to work for those patients requiring time off sick, which promote effective pain management, for those in discomfort, which manage disease for those with long-term conditions and which maximise movement and function for those with a lack of mobility, thereby improving the quality of life for each patient

To support patients with self-management strategies and lifestyle changes, with a focus on the needs of the individual, providing timely specialist intervention where and when appropriate but facilitating independence and autonomy, promoting the self-management of a person's health and well-being in a care closer to home or home environment.

To build upon partnerships and collaborative working and support primary care practitioners & other clinicians, in the identification of patients with more acute conditions and in the continuing care of people with less complex / long-term conditions or during times of stability, through education, effective working relationships, web site access and the availability of an advice telephone line / email enquiry box

To provide expertise to in-patients at Royal Blackburn Hospital and Burnley General Hospital, as required, giving direct care to patients and supporting other clinicians in their care, with clinical management plans that optimise any length of stay and facilitate a successful planned discharge, returning care to the community where clinically possible and appropriate

To demonstrate a movement in the clinical threshold for accessing specialist care, from secondary care to community provision, thereby reducing demand for secondary care & releasing scarce resource; ensuring that, in any necessary onward referrals, the patient has an identified clinical need, is fit and ready for secondary care and agrees with the care plan, through informed choice

To maximise the use of new innovations and technology where appropriate and where there is evidence of efficacy

To support an innovative flexible approach to service delivery; delivering one-stop shop clinics, drop-in clinics, web based information, telephone follow up consultations, advice lines, enquiry email in-box and out of hours appointments

To deliver evidence based care that meets NICE guidance and National standards

To respect patients' rights and diversity, and promote action to reduce inequalities in people's health and experiences of healthcare.

The key objectives including self –management and practice guidance will be available on the website:

www.elht.nhs.uk/departments-wards-and-services/MSK-pain-rheum.htm

3.2 Service description/care pathway

The community based Integrated MSK service pathway is based on the following principles:

- The right people
- Doing the right thing
- In the right order
- At the right time
- In the right place
- First time
- With the right outcome
- All with attention to the patient experience

The broad model of service for integrated MSK care, within East Lancashire, is shown on page 15.
The key elements within the model and care pathway, applicable to the specialist MDT integrated MSK service, are outlined below:
GP Advice, guidance & education
Referral through a Single Point of Access
Triage
Clinical Assessment
Diagnostics
Treatment
Patient education & support in self-management
Onward referral
Discharge

Patients may move through the pathway in a different order to that outlined above and may not be assessed as appropriate for all elements

GP Advice, guidance & education

A telephone advice line, within the same day response during core working hours, will be made available to GPs; this will facilitate advice and guidance from a GP with Special Interest or a Specialist practitioner within the MDT (with access to the GPwSI or Consultant or Clinical leadership, if required)

Specialist advice will assist GPs to manage patients in primary care and achieve optimal outcomes, without the need for referral into the service.
If a referral is considered appropriate, the specialist advice will provide guidance to GPs, supporting a greater understanding of MSK conditions and will provide feedback & assurance in respect of appropriate clinical management plans.

Referral through a Single Point of Access

Referral will be made into the service by an East Lancashire and Blackburn with Darwen GP, or by an accredited healthcare professional, through a Single Point of Access, when it is considered that specialist MSK care is required and where there is patient agreement.

Referral will be undertaken in accordance with agreed protocols, care pathways from the Map of Medicine and locally determined care pathways, in line with best practice.

Information provided on the website

www.elht.nhs.uk/department-wards-and-services/MSK-pain-rheum.htm

A locally determined Minimum Data Set for each referral, will ensure the service receives adequate clinical information and undertakes accurate triage

Referrals for MSK conditions will be made via the national Choose and Book (CAB) system into the Single Point of Access and will be received by the service within one working day from the time that the decision to refer was made.

Triage

Triage will consist of a non -face to face assessment to determine the appropriateness, timing, sequence and pathway that the referral will take. It is based on an evaluation of the referral information and will be undertaken by a suitably qualified MSK practitioner, to jointly agreed protocols. Referrals will be made to the service using the agreed triage proforma –see attached

The outcome of triage will be communicated to patients, who will be invited to arrange their first appointment. The offer of appointments will comply with the 18-week rules suite.

Where clinical information is incomplete or where the referral is inappropriate / outside the offer of NHS treatment, as outlined within East Lancashire CCG policy, the referral will be privy to discussion with the referrer or returned to the referrer with caveats and clear guidance and instructions on next steps.

The integrated MSK service will strive to ensure that sufficient appointments are available, to meet agreed demand thresholds & volume of activity, for referrals triaged to the service, and be made available on Choose and Book.

All patients will be offered an appointment within 2 weeks of receipt of referral, such that patients have opportunity for assessment, diagnostics and agreed plans of care within 6 weeks for MSK and Physiotherapy access and with an 18 week RTT access for Rheumatology and pain Management Services.

Clinical Assessment

Clinical assessment will require a face-to-face consultation between the patient and the appropriate healthcare professional, from within the MSK MDT. The initial assessment, of the patient's condition and the impact this has on the individual's health and well-being, will inform the plan of care, tailored to each person's needs.

Validated assessment tools will be used, where possible and appropriate, to enable the service to identify the health state of each individual at initial assessment, during the episode of care, as required and at completion of treatment.

Patient's will be engaged in the assessment and will be invited to identify both short and longer term personal goals that are relevant & reasonably expected to be attained, following treatment and/or support in self-management programmes.

See website www.elht.nhs.uk/departments-wards-and-services/MSK-pain-rheum.htm

The proposed plan of care will be discussed with each patient, outlining any risks and benefits and shared decision making will inform the agreed way forward and provide consent.

Where possible and appropriate, the service will deliver a one-stop-shop approach, where diagnostic tests / treatment / procedures / therapies will be provided at the same initial assessment appointment.

The outcome of assessment will be recorded within the patient's health record and on the patient information system.

The outcome of clinical assessment may be an identified need for diagnostics / delivery of the agreed plan of care by the multi-disciplinary MSK team / onward referral / discharge to the referring clinician.

Diagnostics

Investigative tests, clinically appropriate to the individual need, will be identified at assessment and/or clinical review, during a patient's journey, and undertaken to aid and support the identification and extent of the patient's MSK condition.

Where possible and appropriate, diagnostic tests will be carried out at the initial assessment.

Access to any second line investigative tests will be determined in line with clinical assessment to ensure the patient receives early treatment and effective care with the optimal clinical outcome.

Diagnostic tests based on clinical assessment and person's needs, will be carried out in the community if practicable thereby releasing capacity in secondary care to support timely access to diagnostic tests, for those patients with complex conditions / urgent care needs.

Diagnostics tests will include access to nerve condition studies, radiology and pathology.

Treatment

Treatment will be delivered by a member/s of the community multi-disciplinary MSK team and will commence within six-weeks from receipt of referral

All treatments offered and provided, within the service, will have an evidence base and will be tailored to individual need.

Treatment provided by appropriate qualified members of the MDT may include, for

example:

- Physiotherapy assessment, with a range of treatment options available, according to assessed need
- Podiatry assessment and treatment
- Orthotics assesment and provision
- Extended Scope Practitioner or GPwSI assessment and intervention as required
- Joint & soft tissue injections, expertly delivered by members of the MSK MDT who have the necessary accredited training, skill and competence
- Medication regimes
- Clinical Psychology

All delivered under the leadership and governance of the Clinical Lead.

MSK surgery for carpal tunnel syndrome may be delivered within the community and will be categorised as minor “clean room” treatment, not requiring an overnight stay. Any carpal tunnel surgery would be delivered by clinicians with accredited training and qualification. Carpal tunnel surgery, offered by the MSK service, will not include general anaesthetic work; therefore, the only day case procedures undertaken will be by local anaesthetic.

The service will effectively manage a low rate of DNA.
All treatment will be fully bookable and be delivered within a “one-stop shop” approach where clinically possible & appropriate.
Patients will be provided with routine follow-up appointments, where it is agreed it will add value to the person's care and clinical outcome.
Patients will be given the opportunity to initiate a follow-up, should they have reason to require this and should this be clinically appropriate to their care.

Any complication, directly linked to an episode of treatment, will be dealt with by the service, unless it is an emergency.

Clinical outcome measures will be used to determine the results of all aspects of treatment and intervention, for each patient, within the service. Patients will also be invited to report health and health-related quality of life outcomes, from their perspective (Patient Reported Outcome Measures).

The service will regularly review the clinical outcomes and establish standards against which to continuously improve all aspects of practice.

The service will work to an agreed DNA protocol and ensure that, for any patients who do not attend their appointment/s, health records are clinically reviewed and safely managed.
If the clinical review indicates a need for follow up within the MSK service, the department will contact the patient and ensure they are aware of the clinical reason they are required to attend and the importance, therefore, to agree and keep the next appointment.
If the clinical review identifies an indication to discharge, the GP will be notified without delay and the patient will be copied into correspondence.

The service will effectively manage cancellations

Patient education and support

The integrated MSK MDT will demonstrate attitudes and behaviours that embrace the stepped care model; assisting in the management of demand for MSK care, through the development of an activated and engaged patient and the delivery of supported care within primary care and as close to home as possible.

All patients with a long-term MSK condition, seen by the service, will have the opportunity to be actively engaged in comprehensive self-management programmes, adopting shared care decision making principles, to enable each person to recognise and respond quickly to symptoms of an exacerbation and effectively self-manage their condition, where possible.

Onward referral

The integrated MSK service, under Clinical leadership and with interface to existing community teams, is intended to deliver a comprehensive range of specialist treatments and long-term condition management and effectively manage a patient's care within the community, by default.

Onward referral will be limited to the requirement for orthopaedic or other specialist skills, for such as; surgical assessment / multiple pathologies / complex & serious disease, where the diagnostic assessment and/or treatment can only be delivered by secondary/tertiary care.

Any consideration for onward referral will be made in line with best practice, college guidelines, locally agreed protocols and NICE guidance.

Onward referrals, through choice, will be made within two working days of the decision to refer and must include an Inter Provider Transfer Minimum Data Set form to enable accurate Referral to Treatment Time (RTT) tracking and reporting.

Discharge

Discharge planning aims to improve the coordination of effective and efficient care within the integrated MSK service, support self-management after a patient’s discharge and optimise longer-term clinical outcomes.

Effective discharge planning will require the MSK MDT to anticipate any potential clinical challenges and potential barriers to discharge, through the delivery of a comprehensive assessment and on-going clinical review, working collectively and in close collaboration with the patient.

Discharge planning will commence at the outset of care.
Assessment will outline individual needs, identify treatment goals, agree a plan of care and indicate an expected length of treatment.

Discharge will occur when the member of the MDT and the patient agree that treatment has optimised progress towards or has achieved goals and delivered optimal clinical outcomes.
The patient will be directed back to the referring GP or accredited healthcare professional, at discharge.

At the point of discharge, the member of the MSK MDT will produce a discharge report, conforming to an agreed standardised format and minimum data set.
The report will include, where appropriate, a health maintenance programme, to be delivered by primary care and / or the patient, to ensure effective and successful longer-term management of the MSK condition, without the need for re-referral.
The report will, however, outline any indications for re-referral, should there be a clinical need that would require further specialist MSK care.

The referring clinician will receive the discharge report no later than five working days of the patient being discharged.
A copy of the discharge documentation will be sent to the patient.

3.3 Population covered

Patients registered with an East Lancashire and BwD GP.
MSK: adult over 16 years
Rheumatology: all age provision
Pain Management: all age provision

3.4 Any acceptance and exclusion criteria and thresholds

The service will include clinical triage, through a Single Point of Access, for all East Lancashire GP MSK referrals; including all referrals, considered by the GP as appropriate for Orthopaedics and including all ages.

Triage outcome, for those with more complex, specialist or potential surgical needs, will necessitate clinical management by secondary care and will be onwardly directed, by the service, without delay, through agreed protocol and choice.

Triage outcome for those with MSK conditions that are considered appropriate for the integrated MSK service will result in a specialist MSK assessment and appropriate clinical management.

Exclusions

- Known or suspected cancer
- Fractures
- Patients requiring urgent care services, e.g. major trauma
- Procedures of limited clinical value, as defined within East Lancashire CCG and BwD CCG policy
- Non-registerd patients
- Age exclusions as per 3.3

3.5 Interdependence with other services/providers

- ELHT Secondary care – Orthopaedics and other specialities e.g. Respiratory medicine
- Independent Sector hospitals
- Community services; e.g. District Nursing, Community routine podiatry
- Primary care
- Paediatrics (in particular, due consideration will be given to the transition from

children's services to adult rheumatology services)
- Patient support groups and organisations
- Local safeguarding officers and arrangements

4. Applicable Service Standards

The delivery of the commissioned service is underpinned by clinical and performance standards.

4.1 Applicable national standards (e.g. NICE)

NICE guidance relevant to the care of people with MSK conditions:

- CG177 Osteoarthritis – February 2014
- QS 87 Osteoarthritis –June 2015
- CG88 Low back pain - May 2009
- CG75 Metastatic Spinal Cord Compression – Nov 2008
- CG138 Patient experience in adult NHS services: improving the experience of care for people using adult NHS services – Feb 2012

Note: This list is not exhaustive; further information is available at www.nice.org.uk

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

Standards set out in guidance and/or issued by a competent professional body:

- Health Care Professions Council (2013) *Standards of proficiency-Physiotherapists*. London: HCPC.
- Health Care Professions Council (2012) *Standards of Conduct, Performance and Ethics. Your Duties as a Registrant.* London: HCPC.
- Chartered Society of Physiotherapy (2012) *Quality Assurance Standards for Physiotherapy Service Delivery.* London: CSP.
- Chartered Society of Physiotherapy (2011) *Code of Member's Professional Values and Behaviour.* London: CSP.
- Health Care Professions Council (2013) *Standards of proficiency-Chiropodists/podiatrists*. London: HCPC.
- Competency framework for GPwSI in MSK RCGP 2006
- GMC Good Medical Practice 2013

4.3 Applicable local standards

Quality Performance *Indicators*	*Threshold*	*Method of measurement*	*Action if breach occurs (stage 1)*	*Report Due*
• Initial triage of all referrals for Physiotherapy/MSK/Orthopaedic Services from GPs within the Single Point of Access Service within 1 working day of receipt. The referral will be prioritised according to agreed clinical protocols and guidelines. • Following triage, patients who require secondary care/consultant appointments will be offered Choice of Provider within 2 working days. This is an interim arrangement, subject to review of capacity and demand. • Appropriate assessment and clinical diagnosis of patients on initial attendance. • Development of treatment plans in conjunction and agreement with the patient. This will include provision of group sessions, classes etc where appropriate to ensure optimum use of available resources. • After initial assessment, subsequent physiotherapy treatments may be undertaken within an overall average service follow-up ratio of no more than 1:4 • For all other treatments (e.g. GPwSI, ESP, Podiatrist) subsequent treatments may be undertaken within an overall average service follow-up ratio of no more than 1:0.5 face to face contacts. • Direct booking to orthopaedics will remain an option on choose and book: these referrals will be triaged by the MSK service and re-directed if necessary.				

1.5 Expected Outcomes / Metrics • Maximum 18 Week Referral to Treatment compliant Service across all pathways. • All new referrals triaged to appropriate clinician within 1 working day • All patients seen/assessed for GPwSI & ESP within a median wait of 2 weeks • All patients seen/assessed for physiotherapy within a median wait of 3 weeks • All patients seen/ assessed within a maximum of 4 weeks from the date of referral: dependent on the levels of overall demand • Urgent MSK cases seen/assessed within 5 working days. Urgent physiotherapy cases seen/assessed within 7 working days. • Choice of Provider post assessment/treatment made within 2 days of decision to refer to secondary care/consultant clinic • DNA rate to be reported monthly. Rates to be as low as possible (<10%). • Hospital cancellations - service to proactively manage, to ensure as low as possible. • Patient Satisfaction Surveys/Questionnaires – at least quarterly • Redirection and conversion rates within Orthopaedics				
Safe Infection control Medication errors	As per	ELHT	As per contract	Contract performance meeting

Incident reporting	contract	performance report		
Personal & caring Friends and family test Complaints & compliments Choice of appointment Provision of "Out of hours" appointments. Shared decision making with each patient PREMs	As per contract tbd	ELHT performance report		
Effective Delivery of self-management support programmes, PROMs Service outcome measures		EQ-5D		
Efficient DNA rate New to Review Ratio Booking Performance		ELHT performance report		
Responsive Waiting list Waiting time to 1st appointment Journey time through MSK RTT		ELHT performance report		
Well led Clinical & managerial leadership Open & fair culture Learning & innovation Supervision & support				

5. Applicable quality requirements and CQUIN goals

- **Applicable Quality Requirements (See Schedule 4 Parts [A-D])**
- **Applicable CQUIN goals (See Schedule 4 Part [E])**

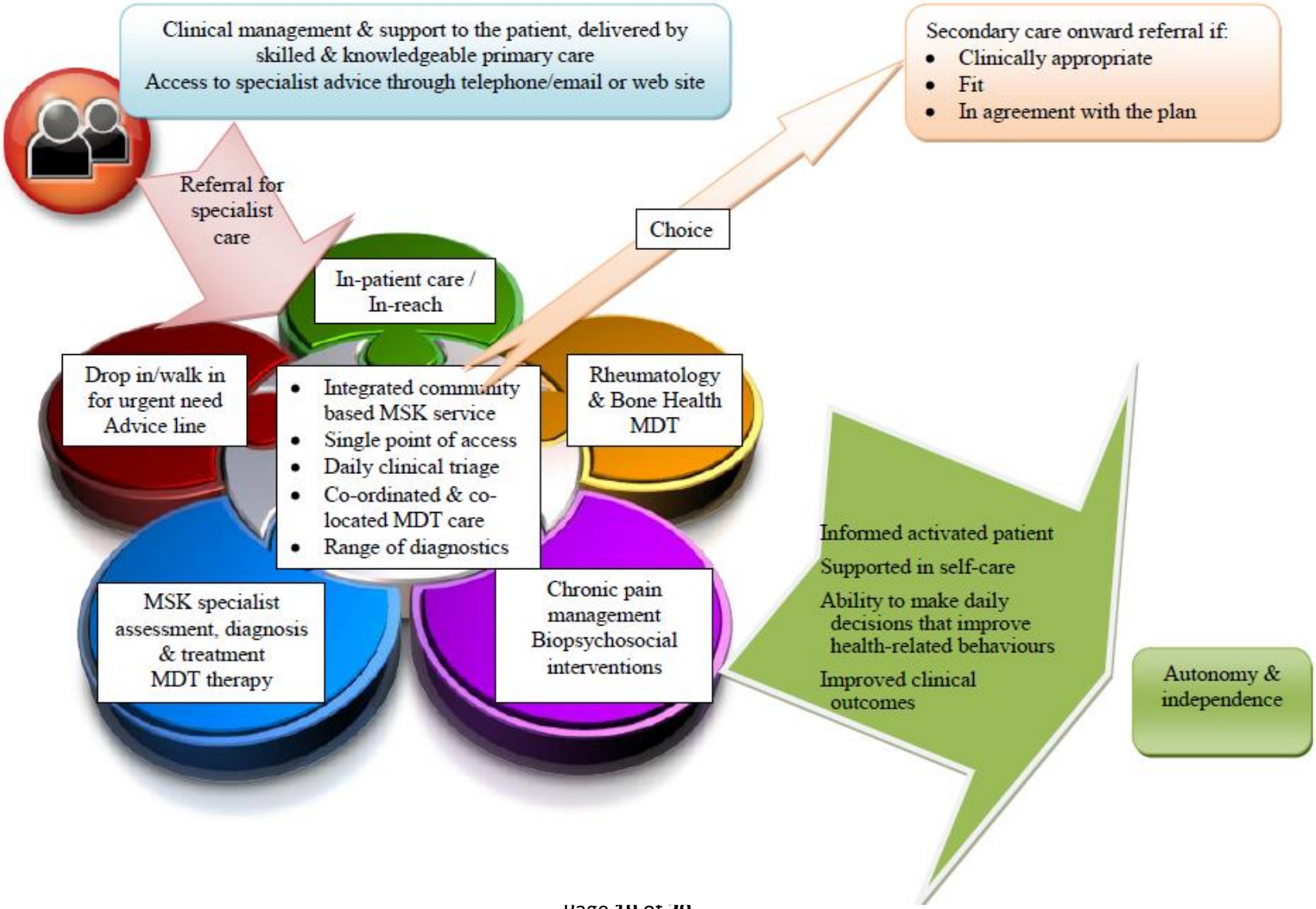
6. Location of Provider Premises

The Provider's Premises are located at:

Health Centre accommodation, within each of the five boroughs of East Lancashire

Royal Blackburn Hospital

Burnley General Hospital


Clinical management & support to the patient, delivered by skilled & knowledgeable primary care
Access to specialist advice through telephone/email or web site
Secondary care onward referral if:
Clinically appropriate
Fit
In agreement with the plan
Referral for specialist care
Choice
In-patient care / In-reach
Drop in/walk in for urgent need Advice line
Integrated community based MSK service
Single point of access
Daily clinical triage
Co-ordinated & co-located MDT care
Range of diagnostics
Rheumatology & Bone Health MDT
MSK specialist assessment, diagnosis & treatment MDT therapy
Chronic pain management Biopsychosocial interventions
Informed activated patient
Supported in self-care
Ability to make daily decisions that improve health-related behaviours
Improved clinical outcomes
Autonomy & independence