SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	001
Service	Community Integrated Musculoskeletal (IMSK) Service
Commissioner Lead	NHS Lancashire and South Cumbria ICB
Provider Lead	
Period	1st August 2018 – 31st July 2023
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Musculoskeletal and Rheumatology Disorders:

Rheumatic and musculoskeletal disorders (RMDs) are common and encompass over 200 conditions affecting joints, bones, muscles, rarer autoimmune diseases and back pain. They are often progressive and mostly cause some form of pain that over time may become chronic. They are the single biggest cause of disability in adults and have a major impact on people's health and quality of life, often impairing normal, physical and social functioning.

RMDs affect over 10 million adults in the UK. An estimated 8-10 million people in UK live with arthritis and 40% of all adults aged 70 or over have osteoarthritis of the knee. 60% of people who are on long-term sick leave cite rheumatic or musculoskeletal problems as the reason. One third of people with rheumatoid arthritis will have stopped working within two years of onset and half will be unable to work within 10 years.

One in every five patients consults with a GP about a rheumatic or musculoskeletal problem and patients often require a wide range of high-quality support and treatment over the short and long term. Furthermore the ageing population will increase the demand for treatment of conditions such as osteoarthritis and osteoporosis.

- Providing Physical Activity Interventions for People with Musculoskeletal Conditions (2017)
- Guidance from professional and voluntary sector bodies such as British Pain Society, Arthritis UK, Arthritis and Musculoskeletal Alliance (ARMA), Chartered Society of Physiotherapists
- 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

Persistent Pain:

Persistent pain (lasting longer than three months) is a long-term condition whereby patients have constant pain or repeated bouts of intermittent pain. It can be a condition in its own right or it can be a component in other long-term conditions. Sometimes the underlying cause for persistent pain is unknown. In other cases, the cause of the pain is identifiable. However, once persistent pain is

established in the nervous system, treatment of underlying causes will not necessarily remove the pain. Whilst there are interventions that can help to reduce pain, often patients will need to be supported to learn to live with and manage their own pain.

Persistent pain affects one in eight people (13%) in the United Kingdom. 1.6 million adults per year suffer with persistent back pain and up to 1 in 25 people have chronic fibromyalgia and experience widespread pain all over the body. Persistent pain can significantly impair quality of life and lead to disability. 65% of sufferers report difficulty sleeping and nearly 50% report problems conducting social activities, walking, driving or having a normal sex life. Persistent pain can also have a negative impact on mental health as 49% of patients experience depression.

Myalgic Encephalomyelitis/Chronic Fatigue Syndrome:

Myalgic Encephalomyelitis (ME)/Chronic Fatigue Syndrome (CFS) is characterised by debilitating fatigue and comprises a range of symptoms that include, malaise, headaches, sleep disturbances, difficulties with concentration and muscle pain. There are many different potential aetiologies but the diverse nature of the symptoms cannot yet be fully explained.

Overall, evidence suggests a population prevalence of at least 0.2–0.4%. Approximately half of these people will need input from specialist services. ME/CFS can cause profound, prolonged illness and disability. A substantial number of sufferers are bedridden, housebound or wheelchair dependent. This has considerable impact on the quality of life of people with ME/CFS and their carers.

Patient Self-care and Management:

In order to develop an effective system that delivers quality care, value for money and meets future demand, the role that patients play has become ever more important. Patients spend only a small proportion of their time being seen or treated by a clinician, it is imperative that they are empowered to take ownership and control of their own health beyond the clinician-patient interaction. Health care systems can better support patients through teaching them the skills and confidence to manage their own health and in doing so; patients can be viewed as an asset or a resource to be invested in (Five Year Forward View, 2014 and Next Steps on the Five Year Forward View, 2017).

Supporting national documents and strategies:

- NHS Five Year Forward View (2014)
- Next Steps on the NHS Five Year Forward View (2017)
- Right Care Commissioning for Value (2016)
- NICE guidance, pathways and quality standards where available
- Delivering Care Closer to Home (2008)
- Guidance and best practice issued by the British Clinical Royal Colleges and British Medical Association

In line with recent strategy publications such as the NHS Five Year Forward View (2014); Next Steps on The Five Year Forward View (2017); Right Care Commissioning for Value (2016); and the Department of Health's Musculoskeletal Services Framework (2006); former NHS Chorley and South Ribble CCG and NHS Greater Preston CCG (referred to in this contract as the 'Commissioners') are commissioning musculoskeletal and related services which must meet the following:

- Delivering care locally organised to support people with multiple health conditions
- Flexibility and innovation in service delivery
- Financial efficiencies and sustainable services
- Delivering a radical upgrade in prevention and self-care
- Reducing unwarranted variation across services

This is underpinned by a number of local strategy and operational documents including:

- Our Strategy for Commissioning Better Health 2014-2019
- Two Year Operational Plan 2015-2017
- Our Health Our Care, Central Lancashire Local Delivery Plan 2016/17–2020/21
- Lancashire Principles for the Commissioning of Health and Healthcare

The Community Integrated Musculoskeletal Service:

The IMSK Service will provide a new, integrated model of care for the population with a focus on prevention and early intervention. The Service will embody a culture of health promotion and wellness taking a holistic approach to patient needs and being accountable for their outcomes.

The former CCGs are commissioning a Community Integrated Physiotherapy, Musculoskeletal (MSK), Rheumatology, Persistent MSK Pain Management and ME/CFS (IMSK) Service to diagnose, assess and treat conditions that do not require specialist intervention at secondary care level.

The Provider of the Service will be required to deliver improved quality of care, patient experience and value for money for the local community through a multidisciplinary approach. The Provider shall, in providing the Service described in this specification, encourage care to be delivered as cost effectively and conveniently for patients as possible, utilising the skills of a variety of clinicians and working closely with other services within the healthcare economy. The Service will also be required to support the sustainability of national directives, by example, meeting 18 week referral to treatment (RTT) compliance and other NHS Constitution targets.

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**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

- **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 evidence 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 Chorley and South Ribble and Greater Preston
- **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 expeditious integrated pathways and choice of appointments and sites across Chorley and South Ribble and Greater Preston
- **Sustainable:** the service is to be both financially sustainable and contribute to future workforce resilience through upskilling of the staff and wider health economy.

3. Scope

3.1 Aims of the Service

By providing a model that is community based, integrated and with a single point of access, the service 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 Provider will ensure that people with MSK and related conditions have access to high quality effective and timely advice, assessment, diagnosis and treatment appropriate to their condition. The approach within the Service shall be based on shared decision making and care shall be structured around a smooth patient journey and seamless, evidence-based integrated care pathways.

Specifically the IMSK Service will include the provision of the following service disciplines:

- Physiotherapy – diagnosis, assessment and treatment
- MSK - diagnosis assessment and treatment
- Rheumatology– diagnosis, assessment and treatment – see additional service specific requirements (Section 3.2.13)
- Persistent MSK Pain Management – diagnosis, assessment and treatment
- ME/CFS service – diagnosis, assessment and treatment

Through better integration of services and timeliness of treatment, the Provider of the Service shall aim to prevent patient chronicity where possible and reduce the need for hospitalisation and /or hospital based intervention. The Provider will only recommend onward referral for patients to their choice of secondary care provider (via Referral Management Centre) should they require highly specialised secondary or tertiary care (See Section 3.2.14).

The Provider will operate within a culture of continuous improvement, responding to patient's needs and incorporating their voice and feedback into the service delivery. Throughout the lifetime of the contract it is expected that the service will work collaboratively with the commissioners and other partners to transform, innovate and iterate to ensure truly excellent and sustainable care.

3.1.1 Objectives of the Service

- To provide an effective, **clinically led** service underpinned by robust governance processes.

- To provide specialist and timely **diagnosis, assessment, treatment** and **clinical management** to ensure optimal and measurable health outcomes.
- To provide a **single point of access** to the service for all people with musculoskeletal and related conditions.
- To deliver care in line with **agreed care pathways** and protocols to reduce unwarranted variation (NHS Right Care, 2016). These are to be jointly agreed with primary care and secondary care. Care pathways should ensure sustainability within the health economy and should not de-skill the wider workforce.
- To ensure **shared decision making** is embedded throughout every step of the patient's journey – "no decision about me without me" (Department of Health, 2012). The service will also adhere to the Commissioner's Shared Decision Making plans.
- To deliver **patient centred care** where the patient is listened to and treated with dignity, respect and sensitivity.
- To recognise the complex biopsychosocial aspects of the patient's condition and understand that the **interaction between the patient and clinician** can be as important as the interventions delivered.
- To provide **holistic care plans** agreed with the patient that meet patients' individual needs and goals to improve their health and well-being within a community setting avoiding unnecessary hospital based intervention.
- To **coordinate care** through **effective multidisciplinary working** ensuring that 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 maximise patient **mobility, function and quality of life** including ensuring effective pain management and a focus on return to regular activities such as work in as short a time frame as possible.
- To **support and empower patients** to self-manage both short and long term conditions equipping patients with the necessary skills and confidence and facilitating independence throughout the patient journey.
- To deliver a **positive experience of care** for patients and an **excellent patient experience** acknowledging the inherent challenges in changing patient expectations, thoughts and behaviours.
- To deliver **evidence based care** within defined clinical pathways, protocols and policies reducing unacceptable variation in care. Specifically demonstrating a movement in the clinical threshold for accessing community and secondary care ensuring that demand is appropriate.
- To adopt an **innovative flexible approach** to service delivery that is responsive to the needs of the local population, supports continuous service improvement and uses **IT effectively** to enhance service delivery.
- To **effectively collaborate** with primary care, secondary care, community care and third sector partners to strengthen a health economy approach towards care.

- To **upskill the health economy** through the provision of **high quality education** within the service (workforce development), and outside of the service to primary care, secondary care, patients community care, voluntary and the third sector, public health, local councils and students in training (See Section 3.2.15).
- To deliver an **equitable service** that is culturally sensitive and meets the population health needs of Chorley and South Ribble and Greater Preston.

3.2 Service description/care pathway

The IMSK Service will be delivered to a high standard, by a multidisciplinary team (MDT) that will include, as a minimum, Consultants, Specialist Nurses, Extended Scope Practitioners, Physiotherapists, Specialist Physiotherapists, Occupational Therapists, Clinical Psychologists, Support Workers and support staff.

The IMSK Service will be provided by a range of expert specialist healthcare professionals, engaged by the Provider and 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 (**Appendix 1**).

The IMSK Service will be clinically led with a single clinician taking responsibility for all clinical accountability and governance (the Clinical Director). Each of the disciplines will also have a named clinical specialist which may or may not be a consultant. *For rheumatology however, this clinical specialist will have to be a Consultant Rheumatologist and this element of the service provision will be Consultant led.*

The model of service will focus on the biopsychosocial needs of the patient. The Provider will work with patients through a collective partnership and a pro-active, multidisciplinary approach to develop an informed and empowered patient.

Patients will have greater autonomy and independence to manage their long term health and well-being and have the ability to recognise symptoms, which may require further specialist advice (e.g. flare up of their disease) and to access appropriate advice and care directly.

The IMSK Service will be responsible for providing patients and the public with access to comprehensive information regarding the service which should include:

- Background to the service provider and core values
- Patient pathways
- Appointment information including venues, what to expect, how to prepare etc.
- How an appointment can be made or amended with the service and how to decline an appointment if it is no longer needed
- Condition specific information across all disciplines
- Self-management information across all disciplines
- Signposting information for other services and groups as appropriate

It is anticipated that this will be in the form of a website which is provided and maintained by the Provider. The information will support the patient to engage in immediate self-management before their appointment as well as throughout their journey.

The Provider will ensure that the Service should identify and make provision for those patients who cannot access the service website and provide sufficient paper information prior to the patient's appointment, as well as throughout their journey. For example, information should be available in a

physical location/s and all information shoulder be provided in formats to maximise accessibility (e.g. other languages, large print, easy read, braille, audio version etc.).

3.2.1 Times of Delivery

The IMSK Service will be operational as a minimum during 8am – 6pm, Monday – Friday five days a week (excluding Bank Holidays) and offer Saturday morning appointments to maximise accessibility for patients.

The Provider will establish mechanisms to give therapists the flexibility to see patients outside of these times and reclaim the time back in order to meet the needs of specific patients e.g. by offering early or late appointments.

These times may be subject to change in line with primary care extended access developments.

3.2.2 Prevention

The IMSK Service has a responsibility to support individuals and communities to stay as well as possible for as long as possible so that they do not access services if they do not need to. In order to facilitate this it is expected that there will be a wealth of information and self-help/health promotion material and hyperlinks/signposting details on the provider's website relating to all elements of the service provision (See Section 3.2).

The Provider will, in delivering the Service, demonstrate commitment to delivering health messages about behavioural and lifestyle factors to the public and local community. This will include engaging with relevant patient and community groups to educate them about disease prevention as well as the promotion of health, wellness and specifically the importance of physical activity

3.2.3 Access to the Service

The Provider of the IMSK service will ensure that high quality, appropriate referrals are received which give sufficient information to make effective triage decisions. It is envisaged that the Service will be accessed via direct referrals from Primary Care, but it is also expected that there is a direct access route of referral/access for patients requesting physiotherapy services.

All patients registered with GP practices across Chorley and South Ribble and Greater Preston are referred to Secondary Care and/or Tier 2 services via the Referral Management Centre (RMC) using the NHS e-Referral Service (e-RS). The RMC is commissioned by the ICB and is provided and managed by the Midlands and Lancashire Commissioning Support Unit (MLCSU).

3.2.4 GP referral

Referrals will be made via the Referral Management Centre using the national e-Referral System (e-RS).

The Provider will utilise an agreed standardised referral template detailing a minimum set of clinical information. The structure and contents of the referral template will be agreed between the IMSK Service Provider and the Commissioners.

3.2.5 Self-referral

It is the expectation that the Service will provide a direct access route of referral for patients who require standalone physiotherapy services. It is anticipated that this will be a direct telephone number initially, but may also include electronic pathways as an additional access route.

It is essential that this self-referral physiotherapy pathway is integrated to the IMSK Service and any patients that require access to the physiotherapy element of the service are not re-directed to Primary Care to be able to enter the service but that they can be booked directly.

Providers will need to liaise with the RMC and the MLCSU teams to determine the most appropriate pathways and systems to ensure that patients can access the services and to develop and implement the most appropriate IT infrastructure to facilitate this pathway. This will have to be compliant with the e-RS guidelines and will require ICB approval.

The Provider will also need to offer alternative access for those patients who do not have phone or internet access and make necessary provisions for patients with additional needs (e.g. language, hearing). The Service will have a robust monitoring and feedback mechanism at the GP practice level. This intelligence will be used to prevent pathway misuse.

3.2.6 Single Point of Access (SPOA)

The Service model implemented by the Provider will operate via a single point of access. All self-referrals and GP referrals from the following e-Referral specialties will be clinically triaged by the Provider.

- Physiotherapy
- Orthopaedics
- Rheumatology
- Pain Management
- ME/CFS referrals – as there is not a specific referral specialty these will be sent under the Rheumatology specialty as the majority of ME/CFS services are recorded under Rheumatology on e-Referral

The IMSK Service will ensure that patients are triaged efficiently and effectively onto the correct pathway within or outside of the service

3.2.7 Triage

The triage process will take place through the e-RS for GP initiated referrals and will be facilitated through the Referral Management Centre (RMC). Self-referral will be triaged via providers own systems. It is a requirement that the IMSK Service will provide a clinical triage for all referrals. This is an essential part of the service and fits with the wider demand/referral management strategies for the ICB. Triage is expected to ensure high quality, appropriate patient referrals are undertaken and that patients are seen in the right place, at the right time, by the most appropriate clinician.

Receipt of referral is defined as the point where the referral drops into the queue for clinical triage by the IMSK Service.

The triage role must be undertaken by experienced clinicians within the IMSK Service (e.g. Extended Scope Practitioner) that have extensive knowledge and experience of all disciplines within the service and the local health economy, pathways and providers.

The IMSK Service will clinically triage all referrals received for the specialties listed within Section 3.2.6 and perform one of the following for each referral:

- Accept and forward for booking to either Secondary Care or to the IMSK Service
- Return to the referring GP on the basis of a non-commissioned procedure, or PLCV (Procedure of Limited Clinical Value)

- Return to the referring GP with advice to manage in Primary Care
- Return to the referring GP requesting further information to be included
- Reassign to a more appropriate specialty/clinic
- Upgrade to urgent where appropriate and forward to the appropriate pathway; also upgrade to a 2 Week Wait referral for suspected cancer patients

The outcomes of the clinical triage will be expected to be recorded and routinely reported to the Commissioners to highlight the impact of the triage function within the pathway. There will be a required feedback mechanism to GPs at the point of the triage decision to aid with learning if there are issues relating to referral quality or appropriateness.

NHS Lancashire and South Cumbria ICB has a comprehensive Procedures of Limited Clinical Value (PLCV) and Prior Approval Process; these are both detailed within the contract under Section G 'Other Local Arrangements, Policies and Procedures'. The Provider is expected to comply with the commissioning policies and prior approval policy set out in the contract.

The service does not need to operate triage at defined times of the day however there is the expectation that referrals will be triaged within 2 working days from publication on the review list designated to the service on e-RS. It is also expected that there will be wider access to the MDT to support triage decision making when necessary.

3.2.8 Booking Appointments

The IMSK Service must offer directly bookable slots for first appointment (including telephone appointments) which will be booked via e-RS for GP initiated referrals facilitated by the RMC (MLCSU). Self-referrals will be booked via the provider's own system. It is expected that sufficient appointment slots are published by the service supporting any national and/or local targets for Appointment Slot Issues (ASIs).

The RMC will be responsible for contacting the patients and booking their first appointment for GP Initiated referrals, patients will be offered choice with regards to appointment location and dates. These choices will be determined by the outcome of clinical triage.

The Service will ensure that patients have sufficient information prior to their appointment so that they are prepared and know what to expect when they access the service. All patients will receive information and advice about self-management so that they can start to self-care as soon as possible (See Section 3.2).

The Service will be expected to be readily available and contactable to all patients prior to first appointment and also whilst they are within the service. The Provider of the Service will be responsible for answering queries, administrative coordination of care, signposting patients to online and offline resources and escalating concerns/queries to clinicians.

It is anticipated that patients accepted into the IMSK Service will be triaged onto one of three broad pathways based on their clinical need and urgency.

1. *Telephone physiotherapy* – patients suitable for telephone physiotherapy assessment, advice/guidance and signposting. The IMSK Service will contact or attempt to contact patients **within 5 working days** of receipt of referral.

2. *Routine patients* – patients will need assessment and treatment/management. They may also need one or more of the following; diagnostics, clinical care coordination, MDT approach and follow up/s. Patients will have their first appointment and be assessed within a **maximum of 5 weeks** from receipt of referral.

3. *Urgent patients* – patients who require urgent intervention to prevent deterioration in function, including those with suspected persistent synovitis will have their first appointment and be assessed within a **maximum of 3 weeks** from receipt of referral

3.2.9 Telephone physiotherapy advice

The Provider will ensure that patients that are suitable for telephone physiotherapy will receive rapid assessment, advice, guidance and signposting via telephone from a suitably qualified physiotherapist in order to facilitate quick and effective treatment and prevent chronicity.

Once patients have been deemed suitable for telephone physiotherapy from triage, an IMSK physiotherapist within the Service will make telephone contact or attempt to contact with the patient within a maximum of 5 working days from referral. Within this conversation it is anticipated that the following information would be captured :

- All relevant clinical details
- Any symptoms suggestive of serious pathology will be identified managed via the correct pathway
- The sTarT back tool is completed if appropriate
- Immediate self-management advice including any movement exercises will be provided if appropriate
- Patients are signposted to self-management resources (See Section 3.2) and any other community resources as appropriate

Following this initial conversation it is expected that all patients will continue onto the most appropriate clinical pathway (See Section 3.2.14 for further details on expectations for patient consultation). Where patients need to be re-directed to an alternative provision outside of the IMSK Service they will be transferred to the RMC to facilitate the onward referral to the appropriate provider.

3.2.10 Service Delivery Model

Once accepted into the service it is expected that the patient will receive the most appropriate treatment pathway to reflect the patients' individual presenting needs and complexity of condition. The Provider will ensure that the patient is assessed holistically and that their biopsychosocial needs are identified which informs their action plan.

There will be an expectation that the following suite of options and delivery models will be offered within the comprehensive service provision tailored to the individual patient needs.

Shared Decision Making

In line with the NHS Lancashire and South Cumbria ICB demand management and referral quality improvement schemes the implementation of shared decision making is a key priority within the Operational Plans. It is expected that this will feature within all interactions with patients throughout the service offer of the IMSK provision.

Shared Decision Making (SDM) is a process in which clinicians and patients work together to select tests, treatments, managements and support packages, based on clinical evidence and patient's informed preferences. It involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and a system for recording and implementing patient's informed preferences.

The aim of SDM is to increase patient involvement in decisions about their care and treatment along the service pathways.

Multi-disciplinary team working (MDT)

The IMSK Service will utilise knowledge, skills and best practice from multiple disciplines to aid problem solving and patient care. This will improve the experience of patients and staff as patients will experience a coordinated and seamless service and staff will have enhanced professional opportunities and/or working environment.

Frequent (e.g. minimum of one per fortnight) MDT meetings will take place where the treatment needs of complex patients can be discussed and problems escalated/resolved. MDT meetings may also be used as a quality check to ensure that patients are appropriate to be onwards referred outside of the service (See Section 3.2.14).

MDT meetings must include psychological input to ensure a holistic discussion regarding patient options. Experts should be involved from other providers and disciplines to improve integrated working where possible.

Feedback from MDT meetings will be communicated back to the patient, any further decisions will be made using a shared decision making approach in conjunction with the patient.

Patient education and supported self-management

The IMSK Service will support patients and empower patients to take ownership of their health and wellbeing. The Provider is responsible for enhancing patient activation by increasing knowledge skills and confidence so that patients can effectively follow their action plan and engage in self-management.

There is an acknowledgement that provision of information is rarely sufficient to change behavior, therefore the IMSK Service will provide a suite of solutions designed to enhance patient activation, support self-management and if appropriate, support transition out of the service.

These should be evidence based where possible, embed behaviour change theory and principles and have a focus on physical activity. Examples may include peer support groups, drop in clinics, health coaching or group based exercise classes. The IMSK Service should ensure that any solution or support delivered by the voluntary or third sector is safe, appropriate and effective.

One stop shop

To facilitate effective and efficient service pathways patients should be seen within a ‘one stop shop’ where possible, clinically appropriate and acknowledging patient preference (through shared decision making patients will have had adequate time to consider the information provided and a way of easily contacting the service about the decision they have reached). This is where diagnosis and/or assessment and/or treatment can be delivered on the same day.

Assessment and action planning

Patients will have a comprehensive assessment considering their history and the impact the condition has on their health and wellbeing. Any symptoms suggestive of serious pathology will be identified and managed as per the correct pathway.

The assessment should also consider any yellow flags and the patient's level of activation/self-efficacy. Patients will be assessed using validated scales and Patient Reported Outcome Measures (PROMS) will be collected to provide a baseline to demonstrate effectiveness of treatment.

The IMSK Service will ensure that patients agree an action plan with a clinician that addresses their biopsychosocial needs and meets local targets, quality and reporting requirements. Patients should be seen and treated in the lowest acuity setting that is appropriate and be escalated/de-escalated as necessary.

There will be discussion of the patient's goals for treatment which will inform an action plan and a discharge plan all of which will be agreed with the patient using shared decision making approach. A copy of this plan including any exercises will be sent to the patient.

When agreeing the action plan with the patient it is important to deliver interventions with sufficient intensity to be clinically effective without creating patient dependency. Patients, especially those with more complex needs should be encouraged and supported to engage in self-management throughout their patient journey. In order to achieve this staff will be trained in, and use behaviour change, psychological and motivational techniques.

Note that the patient may be escalated or de-escalated onto other pathways within or outside of the Service at any point as appropriate.

The GP will also have sight of the patient's diagnosis, their agreed goals for treatment including any diagnostic reports and action plan (including exercises) via an electronic medium within 5 working days of the action plan being formulated and agreed with the patient. Diagnoses and treatments will be recorded and subject to reporting.

Care coordination

The IMSK Service will ensure that patients have coordinated care to maximise service efficiency (e.g. to reduce duplication and waste), effectiveness (e.g. to ensure patients are engaged and follow their action plan) and patient experience.

All patients must have their care co-ordinated; any queries related to a patient's care while they are under the IMSK Service should be dealt with by the Service and not go to the GP. The Service will determine the guidelines for which patients are eligible for clinical care coordination. This is to be agreed with the Commissioners. Patients who are eligible for clinical care coordination must have a named clinician as their care coordinator and key service contact.

Follow up arrangements

Follow up arrangements should support the therapeutic process, and the time to follow-up should be appropriate. Unduly protracted reviews can lead to disengagement, whilst overly frequent input can produce dependence. The Service will be responsible for coordinating and booking follow up appointments using an electronic booking system. Information regarding follow up appointments should be routinely recorded.

Treatment types

The Provider will be expected to deliver treatments in accordance with the latest guidelines and evidence based practice utilising appropriately qualified member/s of the MDT. Where possible and clinically appropriate continuity of clinician treating the patient should be maintained. Relevant NICE Quality Standards will be required to be met and the Provider shall evidence achievement thereof.

The Provider will, within the Service, offer a suite of 1:1 and group based treatment/management options including physical and psychological components to suit a range of patient needs and complexities. Treatments will be agreed in conjunction with the patient and a shared decision making approach will be used. The IMSK Service will be required to monitor and record the type of treatment provided.

The following list is not intended to be exhaustive:

- Patient education/training to increase activation/self-efficacy, support self-management and specifically regarding the appropriateness of joint injections and diagnostics
- Injections and ultrasound guided injections (*spinal injections e.g. facet joint injections, epidurals etc. are out of scope*)
- Physiotherapy including specialist physiotherapy (e.g. hand physiotherapy)
- Movement exercises and stretching
- Core muscle stability promotion (Pilates; Alexander technique)
- Manual therapy (manipulation, mobilisation and massage)
- Demonstration of and loan of TENS machine
- Multidisciplinary pain management programmes
- Intra articular or trigger point injections
- Joint aspiration
- Acupuncture – in line with evidence based practice (e.g. NICE CG177 does not recommend it for back pain)
- Combined physiotherapy and psychological programme for back pain (National Spinal Pathway recommendations)
- Psychology/CBT
- Medicines optimisation
- Access to hydrotherapy
- Support worker provision
- Occupational therapy
- As a minimum, standard off the shelf equipment will be provided, including but not limited to, splints or other limb support, walking stick, neck collar, strapping and taping

The Service will also provide, or facilitate primary care to provide patient fit notes.

Joint injections

The Provider is expected to agree care pathways in conjunction with primary and secondary care. It is the intention of the Commissioners that care pathways should maintain the skills and expertise of the primary care workforce therefore the Commissioner’s will have oversight of these pathways.

In line with commissioning principles, joint injections should be delivered appropriately, cost effectively and ethically. Accordingly, settings and protocols will be outlined specifically for initial joint injections and repeat joint injections (Section G ‘Other Local Arrangements, Policies and Procedures’).

3.2.11 Diagnostics

The IMSK Service will ensure that patients receive timely access to diagnostics and that diagnostic use is appropriate, this will be managed through the IMSK Service and is included as part of the service offer.

The IMSK Service will provide or have access to the following diagnostic tests and subsequent reporting functions which will be delivered within the Chorley and South Ribble and Greater Preston area. This list is not exhaustive.

- MRI
- CT
- X-ray
- Nerve conduction studies
- Ultrasound
- Pathology
- DXA for rheumatology patients

Compliance with the national 6 week referral to diagnostic test target is expected.The IMSK Service will be required to record and report on diagnostics. The Provider is expected to use any pre-existing diagnostics where appropriate to minimise duplication. The Provider will have electronic access to, and if necessary use the actual images in conjunction with reports to aid decision making.

3.2.12 Medicines Management/Prescribing

Formulary

The Provider will adhere to prescribe drug treatments in line with all relevant local and national policies, guidance and pathways including:

- The Joint Central Lancashire Medicines Formulary
- The Low Priority Prescribing Policy
- Relevant and ICB approved LMMG guidance and statements
- Shared Care Guidance
- NICE Guidance

Prescribing

Medicines will be initiated, supplied or recommended in line with the local formulary and RAG status (Red, Amber, Green status) by the Provider.

RED drugs will be prescribed and supplied by the Provider

Amber drugs will be initiated or recommended as per local agreements. Where supply is required

by the Provider, [redacted] If a local shared care agreement is in place prescribing responsibility will only be handed to a primary care physician following mutual agreement in line with local guidance.

Shared care is a voluntary agreement. If shared care is not acceptable to an individual patient's GP practice, then prescribing of an Amber drug will be continued by the Provider [redacted]

Non-Medical Prescribing

All governance arrangements for non-medical prescribers will be overseen by the Provider.

Homecare

Homecare may be used to provide medicines administration as considered appropriate by the Provider. All management and validation of invoices for homecare drugs will be completed by the Provider.

Drugs Data Provision

To facilitate auditing by Commissioners to confirm that patients are being treated in line with NICE or locally agreed policies for HCDs, the Provider will be required to submit a Minimum Data Set (MDS) of information in an approved format which includes:

- Medicines name
- Form and strength
- Dose given
- Date given
- Cost to the provider
- The indication for which the medicine was given
- NHS number (which will be pseudo-anonymised by DSCRO) to allow commissioners to cross reference with invoice information e.g. SLAM
- GP practice code

The information should be provided to the Commissioner in a form that is compliant with Information Governance (IG) requirements.

3.2.13 Rheumatology specific requirements

Former NHS Chorley and South Ribble CCG and NHS Greater Preston CCG have not commissioned an acute rheumatology service provision within the local health economy; therefore the IMSK Service must be able to provide a full consultant led; multi-disciplinary rheumatology service.

The IMSK Service will manage patients with a range of conditions including but not limited to rheumatoid arthritis, connective tissue disease, inflammatory arthritis, ankylosing spondylitis, fibromyalgia, polymyalgia rheumatic, regional pain syndromes and metabolic bone disorders.

The Service will deal with the investigation, diagnosis, management and treatment of adult patients with rheumatic conditions. The Service aims to reduce morbidity and mortality, as well as unnecessary hospital admissions. It aims to be comprehensive, flexible and easily accessible offering a wide range of therapeutic interventions also utilising the wider service model and capacity of the IMSK Service.

Rheumatology services are only commissioned for patients who are 16 years of age at first outpatient appointment and over. Patients under the age of 16 years of age with inflammatory

arthritis (IA) who require biologics would need to be initiated in accordance with NICE Guidance by a paediatric rheumatologist.

In line with patient choice requirements, the rheumatology element of the IMSK Service will be open to referrals from all patients. A full rheumatology service will need to be provided to patients from Chorley and South Ribble and , Greater Preston and patients registered with GP practices from other areas.

Once a patient has been triaged by the IMSK Service as suitable for rheumatology, Chorley and South Ribble and Greater Preston patients will be able to choose which rheumatology service provider they wish to be seen as in line with patient choice requirements. This choice discussion will be facilitated by the RMC (See **Appendix 2**).

The Service will also provide consultant in-reach into Lancashire Teaching Hospitals Trust for rheumatology in-patients within two working days from date requested and will be requested from provider to provider. This may be via telephone advice or face-to-face appointment where appropriate. As part of the service development an emergency response pathway will be considered for a 24 hour response.

The rheumatology service provision as part of the IMSK Service will provide specialty specific multi-disciplinary team approaches, this would be expected to include occupational therapists and podiatrists and other professionals were appropriate.

The IMSK Service will be responsible for providing alternative provision for those GPs that currently do not provide shared care, including prescribing or blood monitoring. The Provider will also be responsible for supporting GPs who are engaged in shared care by providing education and advice (See 3.2.12). Path lab support and the transport of the bloods need to be also considered.

Following guidance from NHS England with regards to offender health – it is expected that these patients will be able to access the rheumatology only function of the IMSK Service. We have been advised that:

- The prison service would be responsible for arranging escorts/security to the rheumatology appointment
- The Provider would need to consider waiting areas etc. and other estates requirements if they change the current rheumatology delivery location
- The ICB will request the number of prisoners patients who access the rheumatology service and provide this information as soon as it is received

3.2.14 Exit, discharge and onwards referral

The IMSK Service will ensure that the patient and clinician agree and make a fully informed decision that the patient either:

1. needs a service/treatment that cannot be provided within the service and must be onwards referred via the Referral Management Centre (RMC).

2. no longer needs to be seen within the IMSK Service and can be discharged

Exit from the Service is to be seamless and coordinated.

Discharge planning

Discharge planning will commence with the patient at the outset of care using a shared decision making approach, this conversation will be documented. Prior to exit all patients should complete a PROM post-treatment questionnaire to measure the effectiveness of the treatment/management.

Before patients are discharged/onwards referred they should be satisfied that they have received sufficient information regarding the following:

- Their condition and diagnosis
- Their action plan including how to follow the plan
- Self-management plan - patients should have the ability and confidence to self-manage
- Understand when further intervention might be needed and what to do and how to self-refer back into the service
- Signposting to any other relevant groups or services including the third sector
- Where to find further information, e.g. as a minimum the service website

Patients should receive written information, for example through print outs/patient leaflets or via email.

Time until discharge will be recorded and reported on routinely.

Onwards referral

Patients who are routinely referred onwards onto another service will require an additional check/review by a senior member of staff. For patients who are more complex this will be via an MDT check/review. This is to ensure that the appropriate level of senior accountability is conferred with regards to onwards referral decisions, while ensuring that care is not delayed.

The referral will be made within **three working days** of the decision to onwards refer and the referral will be processed by the provider where patient choice will be offered. The reason for the onwards referral will be recorded, monitored and subject to audit.

If an urgent or 2 week wait referral is identified, the service will ensure that the appropriate pathway is followed. Urgent onward referrals must be completed on the same day that the need is identified.

Note that patients do not need to be discharged in order to be onwards referred (e.g. Pain Management patients who require invasive treatment). In these instances if the patient is not discharged from the IMSK Service it is expected that the service will coordinate with the necessary partners to ensure that care is seamless and not duplicated.

Re-entry into the service following discharge

After patients have been discharged, the IMSK Service will provide opportunities for patients to self-refer back into the Service for up to 1 year for the ***same*** condition without the need for a 'new referral'.

The patient's GP will be notified and kept up to date of any further treatment/management and discharge plans or if the patient is not accepted back into the service, the reason why.

The Provider will also record and report to the Commissioners the number of patients who have re-referred back into the service, the reason for re-referral, the number accepted or not accepted and the reason why patients have not been accepted.

3.2.15 Workforce Development/Training

The Provider will support the local health economy (including internal staff, primary care, community care, secondary care and students in training) in driving up the skills and knowledge of the identification and management of patients with MSK and related conditions.

Workforce & Education

The Commissioners are committed to workforce sustainability and future workforce development. All healthcare professions employed by the Provider should have the appropriate skills and competencies to provide the Services (to include compliance with registration requirements; DBS requirements; fulfilment of appraisal and continuing professional development requirements).

Additionally there will be the expectation that the service will ensure that processes and systems are in place to support multi-professional education and training through the provision of clinical placements for a range of health care professionals (Nursing, Medical, Allied Health Professional).

The Service will ensure that all requirements for training and supervision are adhered to and in place as directed by the relevant professional and regulatory bodies such as; General Medical Council (GMC), Nursing and Midwifery Council (NMC), and Health and Care Professional Councils (HCPC).

As part of the clinical placement infra-structure the Provider will need to engage and establish relationships with the local Universities, Health Education North West (HENW) and the Deaneries.

Research & Clinical Trials

The IMSK Service will undertake learning and development of practice through research and audit activities where applicable.

It is the expectation that any member of staff involved in the conduct of clinical research must be competent to perform their tasks, qualified by education, training and experience. Good Clinical Practice (GCP) is the international ethical, scientific and practical standard to which all clinical research is GCP conducted.

The Provider will demonstrate they are compliant with GCP, as this provides public assurance that the rights, safety and wellbeing of research participants are protected and that research data is reliable.

The IMSK Service will demonstrate:

- How the Service has considered and responded to the approved clinical trials, clinical audit and other well designed studies
- How it has governed and recruited into clinical trials and other well designed studies over the previous year including remedial actions for improving recruitment into approved trials and other well designed studies as needed
- How the IMSK Service reviewed and acted upon the outcome of the audits

3.2.16 Information Technology

The Provider must undertake testing of the IM&T Systems proposed, including those supplied by the Commissioner, by the Provider, by third party suppliers and also of any interfaces and inter-working arrangements between parties or systems, so as to guarantee compliance with all appropriate standards.

- *E- Referral System*: use of the Directly Bookable Service (DBS) for all patient referrals into secondary care;

- *N3*: use of the national network for all external system connections to enable communication and facilitate the flow of patient information;
- *Patient Demographic Service (PDS)*: use of the PDS to obtain and verify NHS Numbers for patients and ensure their use in all clinical communications;
- *NHSMail*: use of the NHSMail email service for all email communications concerning patient-identifiable information or the appropriate local solution

The Provider must ensure that the IM&T Systems and processes comply with statutory obligations for the management and operation of IM&T within the NHS, including:

- Common law duty of confidence;
- Data Protection Act 1998;
- Access to Health Records Act 1990;
- Freedom of Information Act 2000;
- Computer Misuse Act 1990; and
- Health and Social Care Act 2001.

The Provider must be compliant with national standards and follow appropriate NHS good practice guidelines for information governance and security, including, but not exclusively:

- NHS Confidentiality Code of Practice;
- Use of the Caldicott principles and guidelines;
- Appointment of a Caldicott Guardian;
- Policies on security and confidentiality of patient information;
- Risk and incident management system;
- Information Governance Statement of Compliance (IGSoC);

3.2.17 Estates

Wherever practicable, the Provider will ensure that services are delivered via the NHS estate, this will support the ICB and NHS Property Services aims to reduce void space within buildings and to promote better utilization of NHS assets.

Location maps have been provided detailing the various estate available, together with contact information for each building, and a 'referral ranking' for each area. The Provider will be required to utilize the information within the maps and undertake an assessment of the available NHS estate in the first instance to assess its suitability for the delivery of the service.

If the Provider deems the NHS estate unsuitable they must advise the ICB of their reasons.

The Provider will also identify alternative estate for the delivery of the service and provide details to the ICB.

The Provider will ensure that the alternative estate is fully compliant with all applicable statutory obligations – for example the Health and Safety at Work Act 1974/1999, Disability Discrimination Act 2005, Regulatory Reform (Fire Safety) Order 2005, the Electricity at Work Regulations 1989

The Provider will enter into lease negotiations with a landlord at their own risk and cost. The ICB will not underwrite a lease on a Providers behalf.

Additional information in relation to the ICBs Estate Strategy is available via the ICBs website.

3.3 Population covered

The Provider will, in delivering the Service, cover the registered population of Chorley and South Ribble (approximately 181,000) and Greater Preston (approximately 213,000).

The Provider will verify that Chorley and South Ribble or Greater Preston area is the responsible commissioner prior to delivering services to the patient, except in the case of Rheumatology services where the Provider shall be entitled to deliver services to out of area patients who are exercising their right of choice.

Where the Provider delivers Rheumatology services to patients for whom Chorley and South Ribble or Greater Preston are not the responsible commissioner, those services shall constitute 'Non-Contract Activity' and the Provider shall be required to charge the cost of delivering those services directly to the out of area CCG responsible for commissioning that patient's care, and the Commissioners shall not be financially responsible to the Provider.

The Commissioners shall provide the Provider with such reasonable assistance as it may require in recovering the costs of Non Contract Activity from out of area.

3.4 Any acceptance and exclusion criteria and thresholds

The following exclusion criteria shall be applied in respect of the Service:

- Patients under 16 years of age
- Patients who are not registered with a Chorley and South Ribble or Greater Preston area GP – with the exception of patients requiring Rheumatology services (See Section 3.2.13)
- Patients who require emergency care or other Tier 3 care – care pathways will be agreed between the Provider and Commissioners within the Mobilisation Period.
- Non- MSK pain management conditions
- Pre-habilitation and rehabilitation care immediately following/proceeding surgical intervention will remain the responsibility of the provider undertaking the surgical procedure

3.5 Interdependence with other services/providers

Primary care

The IMSK Service will establish effective, collaborative working relationships with primary care to support clinicians to fully manage patients prior to referral and after being discharged from the service. The Provider will understand the current skills and capabilities of the primary care workforce and work with clinicians to augment these.

Requirements

- The Service will accept those referrals which are appropriate where treatment options within primary care are unsuitable for the patient or cannot be delivered within primary care. This will be subject to development of agreed pathways with primary care.
- The Service will be expected to develop pathways that will be detailed for a variety of conditions/symptom presentations and outline what level of workup will be required in primary care prior to referral (including any diagnostics), and what can be managed in primary care post-discharge.
- The Service will provide advice and guidance for GPs which will enable referring GPs to discuss patient cases prior to referral and while a patient is within the service.
- The Service will provide targeted feedback and education to individual GP practices following a referral quality and appropriateness audit. The Commissioners will have oversight of this.
- The Service will be expected to present at GP education events a **minimum of once per year**. This will be information about the service and clinical education relating to all disciplines.
- The Service is expected to provide other clinical education to upskill GPs through workshops, e.g. regarding joint injections, diagnostics and imaging, rheumatology drugs.

- The Service will be expected to provide information to primary care via the service website (See Section 3.2), to aid with the management of patients. This may include referral guidance, prescribing guidance (as agreed with the Medicines Optimisation Team), signposting information or other relevant clinical information.
- The Service will also be expected to share any physical resources (e.g. leaflets) with primary care to aid management of patients within primary care.

Secondary specialist care

The IMSK Service will establish effective, collaborative working relationships with secondary care to ensure that the patient journey is seamless across care settings and that care is not duplicated.

Requirements

- The Service will appropriately escalate patient's care into secondary care where appropriate. This will be subject to agreed pathways with secondary care. Pathways will be detailed for a variety of conditions/symptom presentations and outline what level of workup will be required in the IMSK Service prior to onwards referral.
- The Service will have working relationships with relevant secondary care specialties, e.g. orthopaedics, spinal surgery and pain management. These relationships will commence during service mobilisation.

The following list is not exhaustive but will be likely to include:

- Secondary Care – NHS Trusts and Independent Sectors and Urgent Care
- Primary care
- Paediatric services - the Service is expected to work with paediatric services to ensure an age and stage developmentally appropriate approach and a safe transition of care
- Referral Quality Improvement Scheme Triage
- Other community services including paediatric services where there may be a transition of care, addiction services, weight management services, falls services, minor surgery service
- Professional bodies including educational institutions
- Referral Management Centre (operated by Midlands and Lancashire CSU)
- Patient support groups and organisations
- Third sector and other voluntary organisations
- Local Authorities
- NHS 111

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The service shall be provided in line with the patient's public rights and values as are set out within the NHS Constitution (March 2012) and the following:

- The Musculoskeletal Framework (DH 2006)
- NICE Guidance – Osteoarthritis: The Care and Management of Osteoarthritis in Adults, 2014
- NICE Guidance – Low back pain and sciatica in over 16s: assessment and management, 2016
- NICE Guidance - Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management, 2007
- NICE Guidance - Spondyloarthritis in over 16s: diagnosis and management (2017)
- NICE Guidance - Rheumatoid arthritis in adults: management (2015)

The above list is non-exhaustive list and may be expanded upon by the Commissioners

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

- National Service Frameworks where applicable (Long Term Conditions, Older People)
- Procedures carried out to Royal College of Physicians standards
- The Chartered Society of Physiotherapists – Quality Assurance Standards, 2012
- Health Professions Council – Standards of Proficiency; Physiotherapists, 2013
- Royal College Nursing– Integrated Core Career and Competence Framework, 2012
- Pain society and faculty of Pain Medicine at the Royal College of Anaesthetists, 2015- standards for care of pain generally and pain management programmes etc...

The above list is non-exhaustive list and may be expanded upon by the Commissioners

4.3 Applicable local standards

To be agreed.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4)

5.2 Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

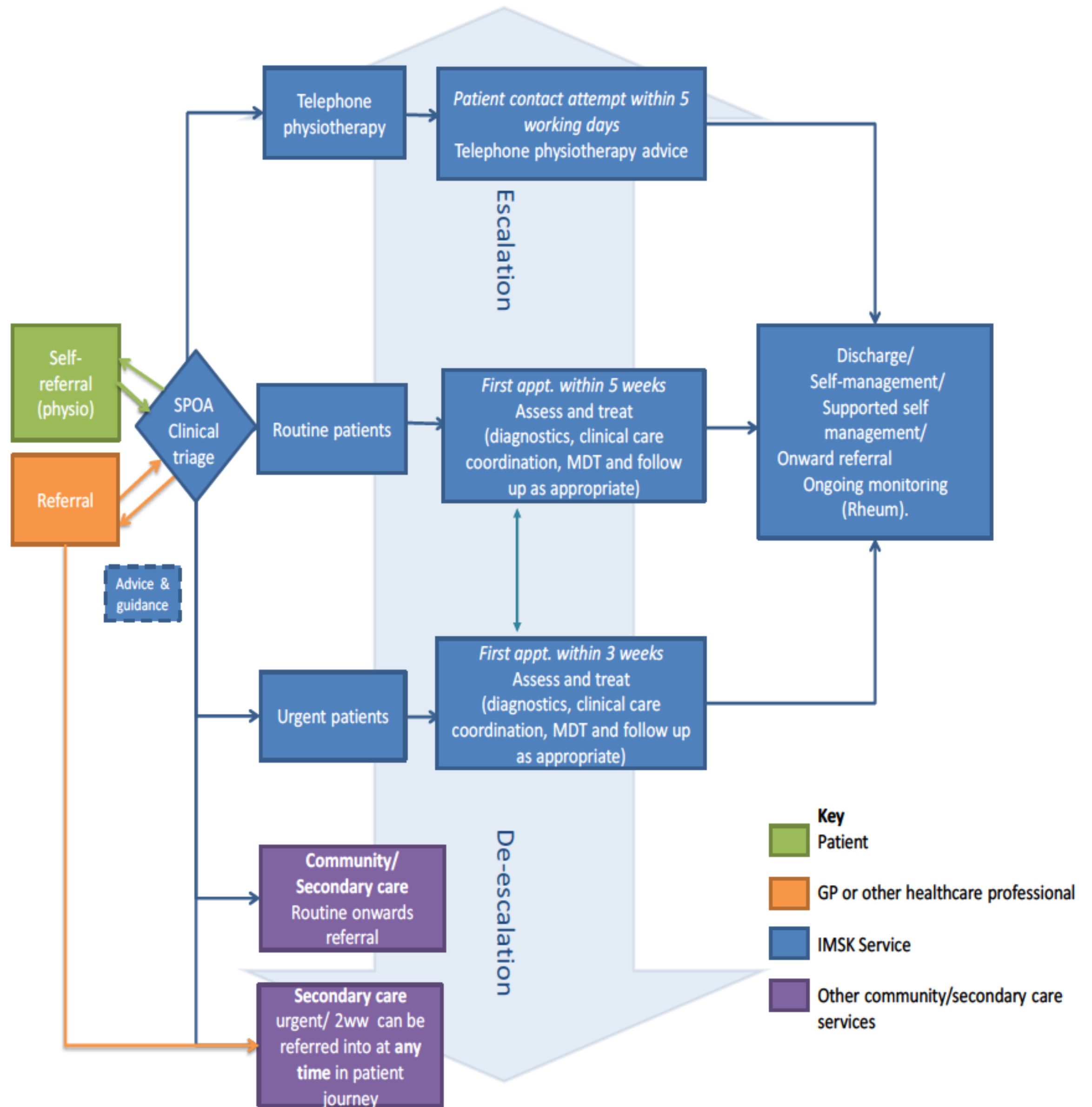
The Provider's Premises are located at:

To be agreed

7. Individual Service User Placement

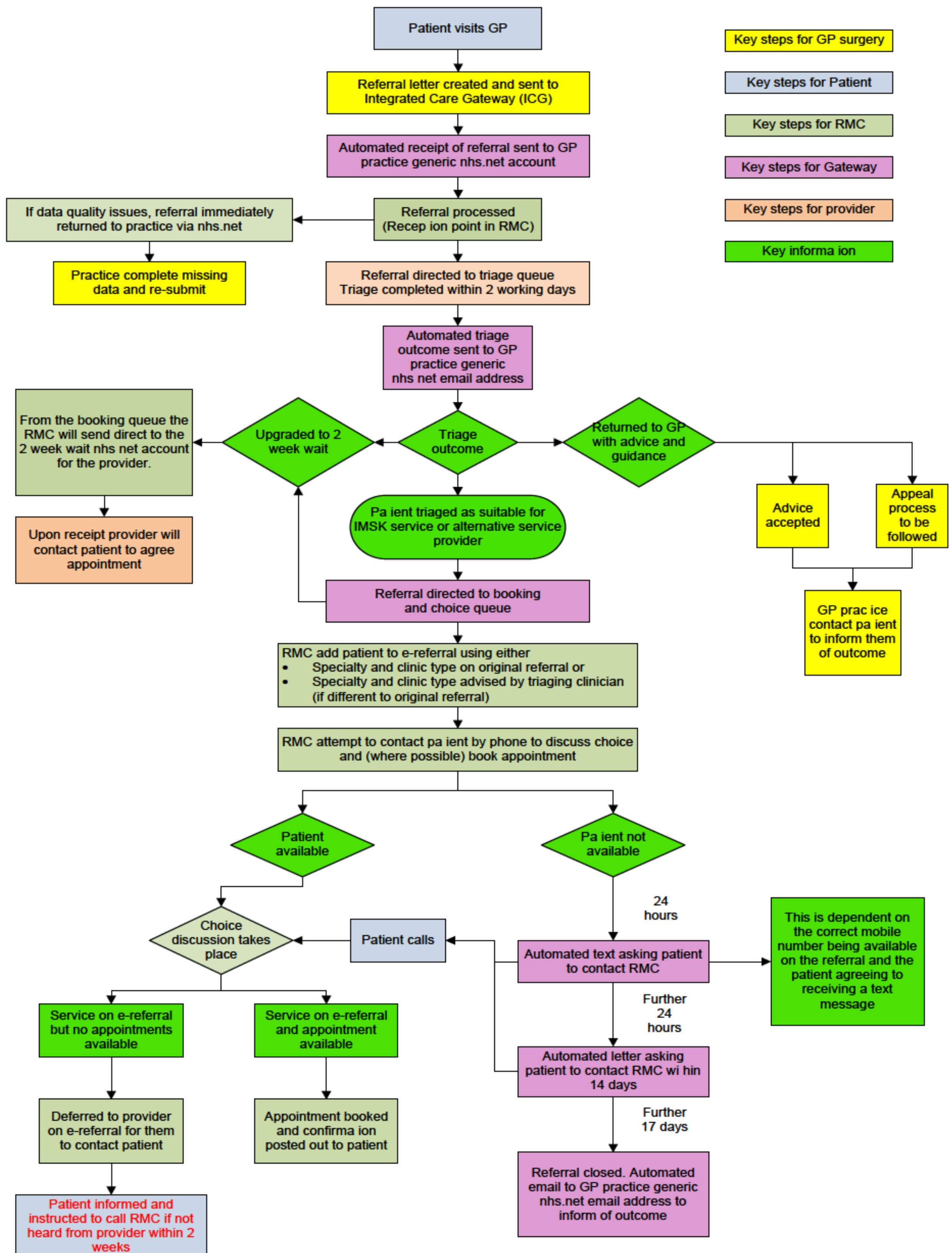
Appendix 1

The IMSK service model



Appendix 2

Process for IMSK referrals via Integrated Care Gateway



Patient visits GP
Key steps for GP surgery
Key steps for Patient
Key steps for RMC
Key steps for Gateway
Key steps for provider
Key informa ion
Referral letter created and sent to Integrated Care Gateway (ICG)
Automated receipt of referral sent to GP practice generic nhs.net account
If data quality issues, referral immediately returned to practice via nhs.net
Referral processed (Recep ion point in RMC)
Practice complete missing data and re-submit
Referral directed to triage queue Triage completed within 2 working days
Automated triage outcome sent to GP practice generic nhs net email address
From the booking queue the RMC will send direct to the 2 week wait nhs net account for the provider.
Upgraded to 2 week wait
Triage outcome
Returned to GP with advice and guidance
Advice accepted
Appeal process to be followed
Upon receipt provider will contact patient to agree appointment
Pa ient triaged as suitable for IMSK service or alternative service provider
GP prac ice contact pa ient to inform them of outcome
Referral directed to booking and choice queue
RMC add patient to e-referral using either
• Specialty and clinic type on original referral or
• Specialty and clinic type advised by triaging clinician (if different to original referral)
RMC attempt to contact pa ient by phone to discuss choice and (where possible) book appointment
Patient available
Pa ient not available
24 hours
Choice discussion takes place
Patient calls
Automated text asking patient to contact RMC
This is dependent on the correct mobile number being available on the referral and the patient agreeing to receiving a text message
Service on e-referral but no appointments available
Service on e-referral and appointment available
Further 24 hours
Automated letter asking patient to contact RMC wi hin 14 days
Deferred to provider on e-referral for them to contact patient
Appointment booked and confirma ion posted out to patient
Further 17 days
Referral closed. Automated email to GP practice generic nhs.net email address to inform of outcome
Patient informed and instructed to call RMC if not heard from provider within 2 weeks