SERVICE SPECIFICATION

SCHEDULE 2 – THE SERVICES

Service Specification

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement
Optional headings 5-7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	NKCCG_MSK_Version 14 (Final_25022016)gc
Service	Adult Integrated Community Musculoskeletal (MSK) Service
Commissioner Lead	Jackie Holdich - CCG Head of Primary Care Gary Crellin - MSK Project Lead - NKCCG
Clinical Lead	Dr Nadeem Ghafoor - Primary Care & MSK Lead
Period	2 years (from 01/10/16 – to 30/09/18) plus 1 year for potential extension
Date of Review	October 2017

1. Population Needs

1.1 National/local context and evidence base

a. National

Musculoskeletal (MSK) conditions are common and encompass over 200 disorders affecting joints, bones, muscles and soft tissues. These conditions include all forms of arthritis, back pain and osteoporosis, some of which can result in long-term functional disability. They are often progressive and mostly cause some form of pain that over time may become chronic. They are the leading cause of disabilities in adults and have a major impact on people's lives, often impairing normal physical and social functioning.

One in four adults are affected by longstanding MSK problems, while there is evidence that disadvantaged social groups have a higher incidence of some MSK conditions and lifestyle factors such as poor diet and limited exercise contribute significantly to the prevalence of MSK conditions. Individuals from diverse ethnic and cultural backgrounds may have different healthcare needs and therefore require different support from health and care services.

MSK disorders have a substantial influence on health and quality of life, and are associated with significant social costs. They are the single biggest cause of disability in the UK with the economic cost estimated at over £7 billion per year in relation to absence from work. 60% of people who are on long-term sick leave cite MSK problems as the reason and patients with MSK conditions form the second largest group (22%) receiving incapacity benefits. According to a recent study undertaken by the Chartered Society of Physiotherapy (CSP), 31% of people experience pain at work at least once a week, with back pain reported as the most common physical problem (65%), followed by shoulder

pain (37%), and neck pain (37%). There is clearly an opportunity to work in a preventative way with local public health services.

The NHS spends around £6 billion annually on the management and treatment of MSK conditions, which makes it the fourth highest area of NHS spending in England. The Musculoskeletal (MSK) Services Framework identified that up to 30% of all GP consultations are in relation to MSK conditions with patients requiring a wide range of high-quality support and treatment. MSK conditions are also the most common reason for repeat GP consultations.

40% of all adults in the UK aged 70 and over have osteoarthritis of the knee and an estimated 8-10 million people in UK suffer with arthritis. The socio economic impact of these conditions have a major impact on the person's life causing sleep disturbance, depression and interference with normal physical and social functioning. The ageing population will further increase the demand for treatment of conditions such as osteoarthritis and osteoporosis.

People with MSK conditions should be able to access high-quality, effective and timely advice, assessment, diagnosis and treatment to enable them to fulfil their optimum health potential and remain independent; achieved through systematically planned services based on the patient journey, and with integrated multidisciplinary working across the health economy. This would follow a similar step-change approach as advocated by the King's Fund in how MSK services are delivered. The idea would be to move away from silo working and into a crucial multidisciplinary approach between orthopaedics, rheumatology, pain management, rehabilitation and physiotherapy supported by occupational therapy, pharmacists, psychologists, community & specialist nurses, chiropractors, osteopaths, orthotics, prosthetics, podiatry, dietetics and all the other relevant disciplines.

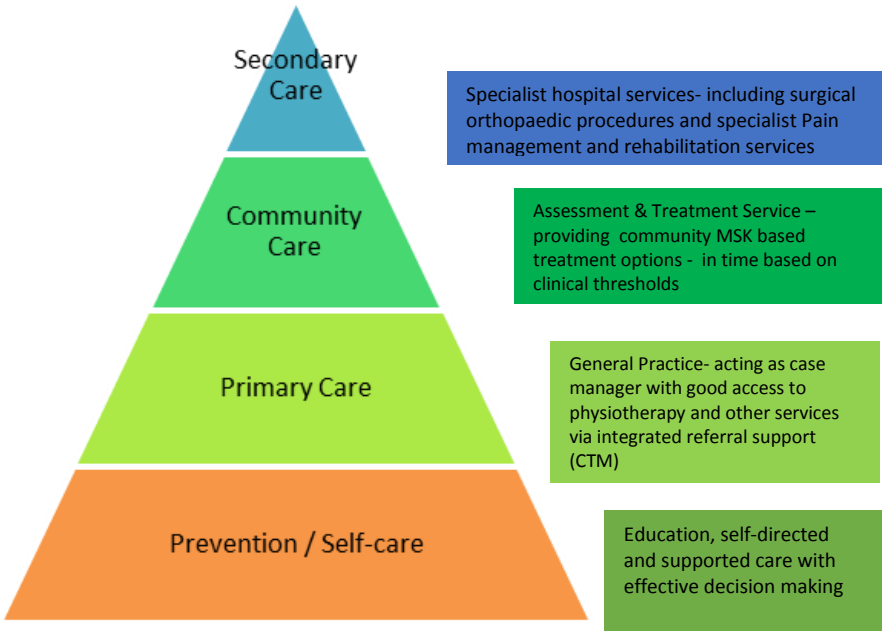
The approach, it is advocated, has to be based on shared care, the promotion of shared decision making and structured around the patient journey and defined through clinical threshold management. Collaboration between, primary, secondary and social care with a focus on prevention, self-care and reducing hospital attendances and admissions, , Increased support provided in a community setting closer to home is a given for the new service model.

The model incorporates staff from a wide range of professional backgrounds working in primary and community care services, so that patients can access care in convenient, community-based locations, minimising waits and unnecessary hospital visits, thereby creating a better process of care leading to improved outcomes.. A balanced and well-planned system of care can:

- treat patients closer to home or work where appropriate
- reducing health inequalities by improving access to services
- provide better information to manage conditions
- manage patient flow through primary/secondary care
- integration of services
- transfer in and out of services at different times
- ensure appropriate/timely referral to specialist care
- develop capacity in primary care
- shorten waiting times to deliver the 18-week pathway
- facilitate an individual's return to independent living

- aligning resources to improve outcomes, performance and value for money
- ensuring quality is in line with national requirements
- supporting collaboration and integrated pathways
- help use capacity in acute settings appropriately
- improve patient experience
- ensuring quality is in line with national requirements

The pyramid model of care for MSK services as part of the transformation of MSK services locally is:



1.2 Local Context

a. There is an increasing demand and a cost benefit for services that promote independence and wellbeing for patients. In addition, like many local health economies, North Kirklees CCG vision is for care at or closer to home, maximising independence and reducing the demands on hospital provision.

b. Patient and Public Involvement in the last year has confirmed that patients see silo working and poor communication between providers to be a concern. The delivery of an effective MSK services across North Kirklees CCG will require an integrated approach involving a variety of organisations and services that patients can transfer in and out of as their needs change.

c. The community MSK services are currently being delivered by a number of inter-dependent services in North Kirklees. The current community MSK service providers are Mid-Yorkshire NHS Hospital Trust (MYHT) and Locala. Locala has recently (October 2015) received a 1-year contract extension to its existing MSK service provision. The contract cannot be extended further (thereby, expiring on 30th September 2016).

d. The current hand surgery contract, provided by Huddersfield Medical Services, expires on 30th September 2016 and the requirements of this service will become part of the MSK contract from the 1st October 2016.

e. Tier 2 Pain Services are currently provided by Pain Management Solutions Ltd until December 2017. This contract will remain in situ but it is expected that this contractor will work closely with the Community MSK Provider.

f. Secondary care access and sustainability is a local health economy issue. Capacity pressures have resulted in longer waiting times to Orthopaedic services than the national standard. In conjunction with Wakefield CCG, Orthopaedic services were reviewed and evaluated in response to capacity pressures in Mid Yorkshire Hospitals NHS Trust (MYHT), which identified that the existing MSK model was inadequate in delivering services to an ageing population and that it required a programme of change broader than solely that of service redesign of the current providers.

g. The current model is no longer affordable to meet the future needs of an ageing population living longer often with long term conditions / co morbidities. Also, the burden of back pain on NHS resources and the continued lack of adequate provision for acute back pain needs to be addressed. From a public health perspective, there is a real opportunity to work collaboratively with the local authority and other agencies to improve overall health gain, to reduce the concept of *worklessness* and to promote a healthier lifestyle that will benefit not just MSK health but other body systems too.

h. Transformation of all MSK services must be based on national guidance to manage the continued pressures faced with local Referral to Treatment (RTT) waits and rise in activity and associated costs. The Mid Yorkshire Local Health Economy (which comprises North Kirklees and Wakefield CCGs and Mid Yorkshire Hospitals NHS Trust) are keen to explore the benefits of an effective Clinical Threshold Management approach.

i. This MSK procurement must improve patient experience and outcomes, ensuring services are in line with national standards and best practice guidelines, adequately representing value for money for the local health economy. A wide ranging inter agency group, called the Prioritisation and Sustainability Group, is in place to oversee Planned Care transformation, including a system wide approach to MSK service delivery,

j. The effectiveness of the co-ordinated, community based MSK service, integrated to manage a range of conditions as part of an overarching service strategy will improve access and ensure patients receive assessment, diagnostic tests and treatment at the right stage of their care, helping to improve patient flow and create a more seamless service.

k. The current MSK Assessment and Treatment services receive c200 referrals a month and these are managed within the RTT 18 week overall pathway. The service is largely centralised in a central Dewsbury location (Dewsbury Health Centre). Secondary care services are provided at Dewsbury Hospital and at Pinderfields in Wakefield.. The option exists for patients to choose to be referred to any provider listed on the Direction of Services.

1. 3 Position statement on Pain services as provided by Pain Management Solutions Ltd and Podiatry as provided by Locala

The provider of tier 2 Pain Services, provided by Pain Management Solutions Limited, is to remain as a separate contract provided to North Kirklees CCG until 31st December 2017. Podiatry Services are provided to the CCG by Locala through the Care Closer To Home Contract. It is expected that both these contractors will work closely with the Community MSK Provider to improve respective patient pathways. This will include discussions on shared care and integrated assessment processes to maximize the benefits that could be achieved by both providers working together.

1.4 Evidence Base

The service will work to the following policy and guidance:

- NHS Core principles
- NHS Planning Guidance - 2016-21 - Sustainability and Transformation Planning
- Commissioning for Quality and Innovation Schemes (CQUIN schemes) Standards etc.)
- National audits
- Commissioning for Value - Right Care
- CQC Essential Standards of Quality & Safety
- CQC Reviews and Inspections
- Royal College Guidance
- Best practice evidence from professional bodies
- Commissioning Guidance and Commissioning Guides
- Data, research and information from Quality Observatories
- Patient Surveys
- Staff Surveys
- Patient experience and feedback
- National Institutes and agencies
- Family and Friends Test
- Delivering Care Closer to Home 2008
- NICE Guidance – Osteoarthritis: The Care and Management of Osteoarthritis in Adults, 2014
- NICE Guidance – Rheumatoid Arthritis: The Management of Rheumatoid Arthritis in Adults, 2009
- NICE Guidance – Low Back Pain: Early Management of Persistent Non-Specific Low Back Pain, 2009

This guidance is not an exhaustive list, providers will be expected to work to new and emerging policy guidance which relates to and links to the delivery of Adult Community MSK services and the well-being of the population of the North Kirklees CCG area.

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 benefits

a. North Kirklees CCG wants a transforming and productive provider that can develop and sustain a community based MSK service that is focussed on disease diagnosis and prevention and high quality treatment

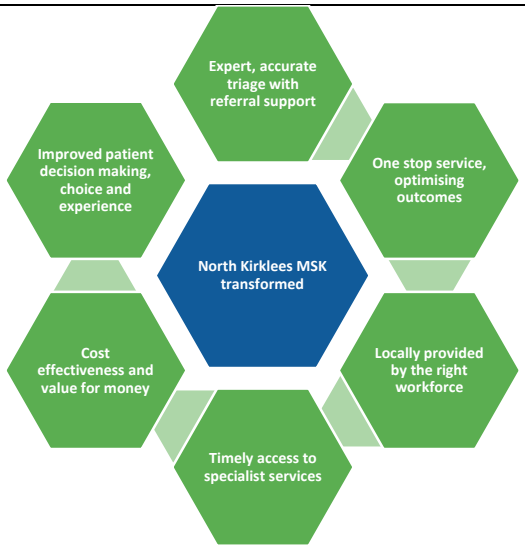
b. The CCG sees real integration opportunities to use the Community MSK provider to oversee and provide access to community hand surgery.

c. It is envisaged that all referrals for MSK and hand surgery will be clinically screened and responded to by the provider via the MSK Hub.

d. For MSK and hand surgery the provider can propose to use either use solely that provider's services, or can rapidly and extensively mobilise through subcontracting a network of CQC approved provision to meet the needs of the demand.

e. It is envisaged that the provider will work closely with Pain and Podiatry providers (see section 1.3) to improve patient pathways. In addition, there is an expectation that the provider will work with secondary care providers to stream line diagnostic, secondary care advice and direct listing as appropriate without the need for GP re-referral.

f. As a philosophy, the provider must understand and deliver the following approach:-



Expected benefits from this procurement include, but are not limited to:

- Evidence of reduction in unnecessary and inappropriate referrals to secondary care
- Evidence that patients actively benefit from health promotion, prevention, self-management and self-care options and demonstrating improvements in these areas over time
- Evidence that patients experienced reduced dependency on medication, better access to pain approaches and can maintain an active lifestyle, and independence
- Evidence of utilization of the *MyHealthTools* App
- For our GPs - Improved clinical outcomes (over agreed times) and evidence of patients satisfaction with care advancing in primary care
- A lower referral rate into secondary care for care that can positively be delivered in a primary care setting
- For the CCG as commissioner, evidence of a positive patient experience through integrated access to community, primary and secondary care services
- Evidence of an improvement in appropriate conversion for agreed surgical procedures in secondary care, in conjunction with work undertaken through Clinical Threshold Management.
- A service model that gains and keeps clinical confidence and has the potential to grow and develop if required.

2.3 MSK Hub for assessment and treatment options

a. The provider will set up and manage an MSK hub, acting as a single point of access for referral support, guidance and advice and access point for treatment after clinical assessment.

b. Its role will be to coordinate care and provide adequate choice to patients by offering a specialist community based Musculoskeletal Assessment and Treatment service for patients identified with a need for musculoskeletal (MSK) and community provided hand surgery services.

c. The hub supports and processes GP referrals, assesses referrals against agreed CCG clinical pathways and clinical thresholds and liaises with patients to ensure that their care is co-ordinated within a community setting wherever possible.

d. The hub needs to be designed to provide a quality, timely, effective and efficient service for MSK assessment and treatment to patients and to also mitigate from the perceived risk that GPs will refer outside this arrangement.

e. The hub will coordinate care by arranging such care required for the referred patient, including accessing diagnostics and secondary care opinion for agreed patient pathways and thresholds without the need to refer back to the referring GP.

2.4 Expected outcomes of the service

a. From a patient perspective, the key outcome of the service is to ensure that all patients are managed effectively in a safe, timely, suitable, environment that can provide community based care in an integrated and caring manner which allows for the right care provided by the right practitioner at the right time. Additionally, patients can themselves demonstrate improvement in terms of mobility, pain management and self-care.

b. From a GP/Primary care perspective, referrals are assessed and allocated in agreed time standards with excellent potential to share knowledge and provide workforce training in general practice. Good communication between the hub and the referring GP is crucial - either to improve the quality of the referral, provide alternative options or to give feedback on how the referral will be dealt with. GP practices will have the confidence that patient care, including secondary care and diagnostics, will be arranged against agreed clinical pathways and thresholds without the need to refer back.

c. From a CCG perspective, to provide a quality, timely, efficient and cost effective, transformative approach to care, to operate in an integrated manner across the local health and care economy in such a way that a quality service to patients that improves outcomes.

2.5 Aims and objectives of service

2.5.1 High Level Aims

- Through a hub approach, the service will provide MSK orthopaedic triage (examination, assessment, diagnosis and where appropriate, treatment) and MSK physiotherapy services for patients aged 18 years or over who have pain or other symptoms, restricted movement or reduced function from an MSK, Orthopaedic or related symptom, set of symptoms, condition or illness.

- In addition, the service will, through its hub approach, provide advice, guidance and onward referral for minor hand surgery as well as direct listing with Secondary Care for primary replacement Surgery after satisfactory and mutually agreeable assessments and diagnostics have been undertaken.

- The overall aims will be to:

a. Provide equity and increase access to primary and community care referred MSK Orthopaedic and Physiotherapy services for the registered population
b. Provide a patient focused service, enhancing patient outcomes, patient choice, patient self-management and the patient experience;
c. Standardise appropriate primary care and other referral pathways into MSK Assessment and Physiotherapy whilst appropriately managing demand across the system e.g. reduce the number of unnecessary and inappropriate referrals into secondary care and provide a direct listing service where it is in the patient's best interest so to do;
d. Reduce the need for long-term physiotherapy care
e. Deliver the highest quality of MSK Orthopaedic and Physiotherapy service provision, in line with agreed Key Performance Indicators (KPIs);
f. Provide a service in line with national guidelines and requirements, for example in line with national waiting time targets to support the 18 week referral to treatment pathway
g. Promote the development of specialisation in primary care;
h. Improve advice and guidance, education and training structures for GPs and Nurses across the CCG for MSK-related care
i. Provide assessed access to hand surgery – either through solely provided services or via provider managed subcontracting support.
j. Ensure that pain assessment and treatment provisions occur higher in the assessment pathway through effective working with the current pain services provider.
k. Ensure that effective links with podiatry through the Care Closer to Home contract are in place to minimise delays in accessing care or treatment from both podiatry and MSK where appropriate.

The scope of the service shall compromise;

l. MSK community physiotherapy – although the assessment function could be provided in a centralised location within the CCG, member practices are keen to explore cluster/neighbourhood access to the provision of physiotherapy for treatment.
m. Providers should develop their proposal(s) based on the provision of community based physiotherapy across a minimum of four defined neighbourhood areas in the district.
n. MSK & Orthopaedic Triage Assessment for primary joint replacement assessment - effectively replacing the need for direct access orthopaedic opinion within secondary care by undertaking the appropriate assessments and diagnostics to support the direct listing of patients with secondary care providers via Choice.

o. Deliver all services within the agreed clinical thresholds resulting in less utilisation of secondary care or improving the conversion rates for surgery by appropriate assessment and threshold management.
p. Work in conjunction with the current Tier 2 Pain services provider to ensure holistic pain assessment and treatment service is in place across the care pathway to reduce pain perception and reduce the associated drug/medicines management spend. Particular emphasis should be made to assessing the benefits from earlier intervention for pain services.
q. To provide minor hand surgery or source alternative arrangements for minor hand surgery and nerve conduction studies.
r. This list is not exhaustive and it is expected that the provider will manage all MSK related conditions within the remit of the service specification.
s. The provider will support the local approach to Clinical Threshold Management (CTM) by actively engaging in local pathway development and work within the CTM Working Groups.
t. The provider will work with secondary care providers to identify conditions and agreed pathways and thresholds that are appropriate for direct primary care to secondary care referral; via the hub (e.g. hip and knee referrals with a defined Oxford or New Zealand measurement score), working up proposals for minor surgical intervention, secondary care opinion to support self-care or establishing protocols for group based treatment approaches and agreeing the mobilisation of Shared Decision Making tools, such as MAGIC.

2.6 Specification of the Service Required

AIM 1	**Provide clinical leadership, examination, assessment and treatment within a comprehensive clinical driven Hub for MSK assessment and treatment, community physiotherapy and hand surgery provision**
Objectives	a. The provider is required to provide a comprehensive clinical hub interface for MSK that delivers and supports high quality, accessible and timely care b. The provider must ensure that the service has appropriate clinical and administrative leadership and provides a single point of contact for all referrers that enables; - Access to advice, information and signposting from appropriately experienced and clinically qualified staff - Provides patients choice of provision centred around their needs and expected outcomes as well as timeliness of care - Clinical triage leading to specialist assessment - Direct referral for advice and/or listing to secondary consultants where appropriate within the MSK care pathway especially for simple primary joint replacement (single not bilateral hips and knees) as clinically assessed and indicated. - Rapid access to diagnostic services - Appropriate utilisation of conservative treatment pathways - Active promotion of self-management and shared decision making c. The provider must ensure that clear links are made with existing pathways and are compliant with local policies for MSK conditions

	d. The provider must give feedback to GPs and other referrers on referral quality and outcome and undertake work to support the improvement of referral information where required under the requirements of the Clinical Threshold Management approach locally adopted across the Mid Yorkshire Health Economy. e. The provider is required to undertake awareness activity with referrers to ensure that the service and pathways are understood, well promoted and accessible. f. The provider is required to develop and distribute appropriate patient information to aide patient awareness and develop a self-care ethos. g. The provider is required to seek service experience/satisfaction feedback from referrers, interface services, patients and carers and develop systems to ensure this feedback informs ongoing service improvement work h. The provider must ensure that service experience and satisfaction is driven by the providers contribution and commitment to deliver the CCG's Quality Impact Assessment i. The provider must ensure that relationships with interface services and stakeholders are established and managed to support effective development of wider networks and pathways that ensure patients can access all relevant support j. The provider must develop formal joint working arrangements, systems and processes with partner and interface services - for example local approved secondary care suppliers , pain services and podiatry (via Care Closer to Home contract) to agree shared care or clinical thresholds for service access.	
AIM 2	**Provide high quality, responsive and efficient musculoskeletal assessment, diagnosis and treatment**	
Objectives	a. The provider is to mobilise services to operate across the North Kirklees CCG – initially from a single site for assessments but bidders need to develop as a minimum four in-reach physiotherapy services across GP clusters/ neighbourhood which could include local authority leisure sites. b. The provider is required to offer appropriate appointment and location options including the offer of early morning and late afternoon/evening appointments within each service location to meet patient needs, Monday to Friday. c. The provider must assess, diagnose, treat and advise patients in line with an agreed treatment plan with good practice access to first line physiotherapy where clinically indicated. d. The provider must utilise the pre referral e-consultation option, accessible via SystemOne in order to support advice and guidance in primary care.	

	e. The provider is required to ensure assessment and treatment plans recognise and support co-morbidities, and wider social and emotional support, health and wellbeing needs f. The provider must ensure treatment is provided by the most appropriate clinician, and offer a choice of male or female clinicians where appropriate to meet a patient's individual needs g. The provider is required to treat patients in an environment suitable to their care needs i.e. rehabilitation delivery may include access to gym and hydrotherapy facilities, (see 2a above as regards Leisure services sites) etc. h. The CCG wishes providers to consider the implementation of group treatment sessions to promote shared or self-care, promote independence and to support wellness. i. The provider must be able to demonstrate that clinical activity/treatment is evidence based and delivered in line with local and national clinical guidance. j. It will be the providers responsibility to ensure that services that are sub contracted are provided by individuals or organisations that hold current appropriate registration with a professional or organisational regulator that oversees and regulates practice and all other relevant standards i.e. safeguarding etc.	
AIM 3	**Ensure patients are involved in decisions about their care and treatment options to meet their needs and are supported to manage their MSK condition and optimise their functional independence and care outcomes (maximizing independence)**	
Objectives	a. The provider is required to involve patients in decisions about their care through the appropriate utilisation of agreed shared decision making tools (for example but not exclusively MAGIC) b. The provider is to implement an appropriate set of patient reported outcome measures that can be used to demonstrate the continued effectiveness of treatment options that captures their view and records progress after each period of clinical intervention (be it a course of injection therapy, a group course of support, a group of patient consultations in a community setting etc.) c. The provider must provide (directly or by contract with a third party in time for the consultation or assessment) interpretation and communication support in order to; -Minimise clinical risk arising from inaccurate communication -Support equitable access to people for whom English is not a first language -Support effectiveness of services in reducing health inequalities d. The provider is required to provide an e-discharge summary for every patient that includes clinical findings, treatment undertaken and recommendations for further management or onward referral as necessary	

	e. The provider is required to provide information and advice to patients, carers and referrers that supports understanding and self-management of their condition including signposting of appropriate printed and online resources/information f. The provider and CCG will agree the clinical criteria for a re-referral system that allows for a brief re-assessment and intervention programme for any patient that is discharged but develops a recurrence of the same clinical condition within 12 weeks of discharge.	
AIM 4	**Enhance the management of patients within primary and community care and actively manage the demand for referral into secondary care**	
Objectives	a. The provider is required to work in partnership across organisational boundaries, primary, secondary and community care to ensure best use of resources, clarity of pathways, seamless care and support development of the local evidence base and best practice; b. The provider is required to develop and effectively utilise clinical networks and partnerships with other MSK providers and interface services; c. The provider is to establish an appropriate dialogue with orthopaedic specialists to provide suitable assessment of patients for primary replacement surgery. And to permit listing based on the assessment; d. The provider is required to work effectively with local Member practices, GPs and GP clusters/neighbourhoods and ensure systems are in place to: - Keep GPs informed about the care provided and diagnosis for all patients (including adequate information at discharge from the Service); - influence the benefits of the service model to member practices to maximise uptake; - Involve GPs and GP clusters/neighbourhoods in the on-going development of services; - Involve GPs and GP clusters/neighbourhoods in delivery of care; - Support education and skills development of GPs and overall primary care workforce to optimise condition management in primary care.	
AIM 5	**Use Innovation and Technology to drive quality improvement, patient experience and value for money**	
Objectives	a. The provider is required to implement systems to deliver joined up IT systems to enable more effective provision of care and increased communication across the service. This includes improving use of the agreed e-consultation tool as a pre referral advice and guidance function; b. The provider must be a registered/licensed user of SystemOne; c. The provider is required to actively engage with and support local integrated care initiatives, for example Care Closer to	

	Home and the Local Health Economy's approach to implementation of the digital road map initiative; d. The provider is required to implement systems that support remote and flexible working arrangements where appropriate; e. The provider is required to implement systems to know immediately whether a patient has been admitted to/ accessed emergency and out-of-hours services and assess the implications for their care plan; f. The provider is required to maintain the E-Referral Directory of Services up to date and consistent with agreed thresholds for service use and agreed pathways of care; g. The provider is required to ensure that electronic systems are in place to actively share all patients' personalised care plans, treatment and discharge information with GPs; h. The provider is required to respond to e-consultation requests via SystemOne gateways to the required standard (within 48 hours of request) and in accordance with the agreed response times; i. The provider is required to market/ communicate their service across the health economy in order to ensure the right patients can access the services when needed (whilst recognising the need for effective demand management); j. The provider is required to utilise innovative technology to support service delivery where this results in more efficient use of resource and empowers patients to self-manage/ monitor their condition, in particular, in clinic access to My Health Tools is required; k. The provider is required to actively involve service users and carers in evaluating, shaping and improving the services they use.

2.7. Service description/care pathway

2.7.1 Service description and key features

The intention of this specification is not to prescriptively define the exact provider model or solution. However, some key features are recognised that would be expected of an effective provider together with the aims and objectives previously defined;

2.7.2 Developing an integrated solution

- The provider works within and contributes to delivery of the vision for primary and community/neighbourhood-based care;
- Patients want their care to be coordinated and not fragmented.
- GP Practices want to see greater access to physiotherapy as a first line intervention.
- The provider will demonstrate initiatives that support wellbeing, reduce the potential for *worklessness*, by accessing primary prevention through standardised and regular lifestyle, diet and exercise prescription/ classes in MSK services or in conjunction with Kirklees Active Leisure Services and Kirklees Council.
- To assist in lifestyle modification, the provider should explore the benefits of working with the voluntary or social enterprise sector in the delivery of life style modifiers, such as weight

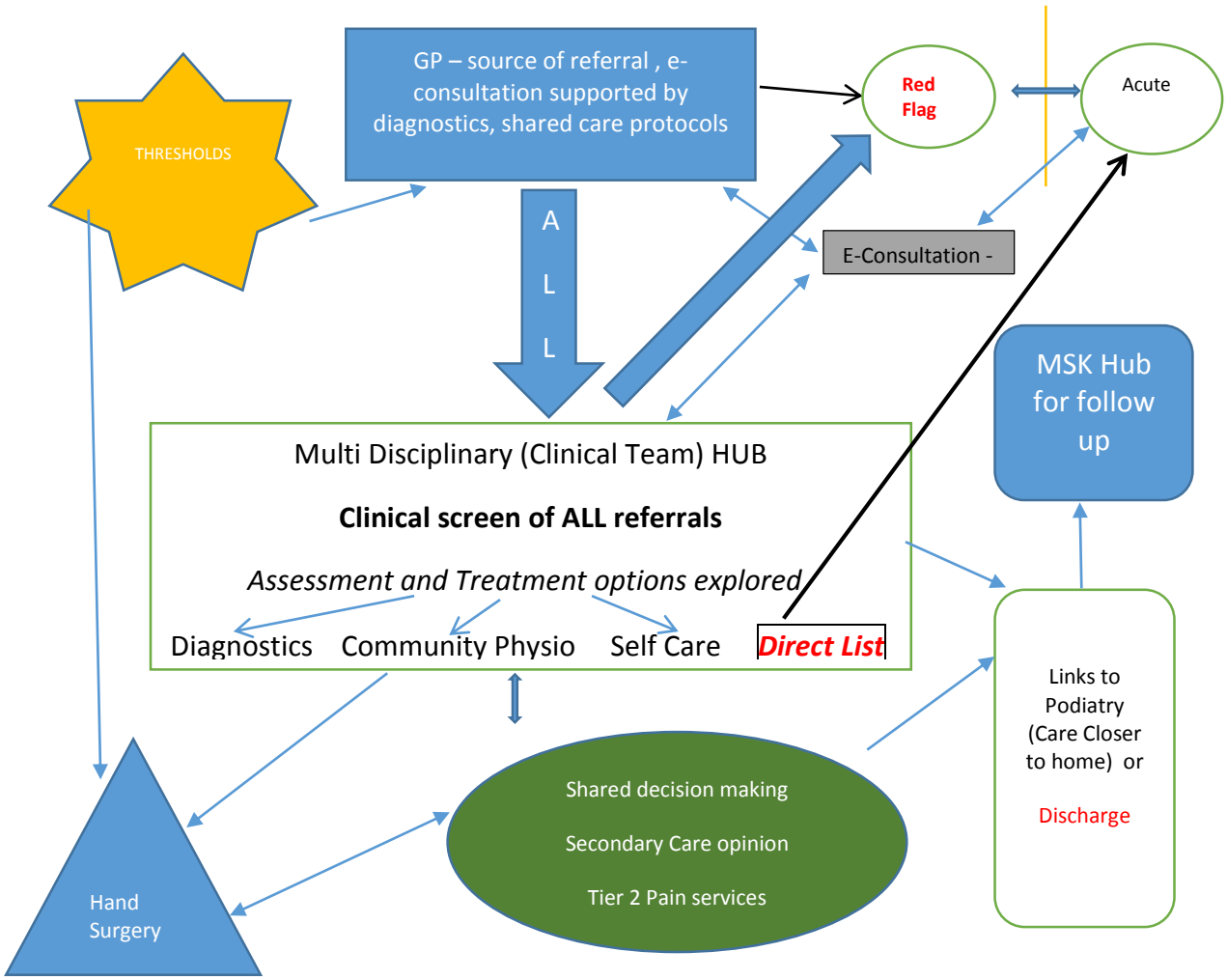
management and smoking cessation. For example, the work of Kirklees Weight Management and the Better in Kirklees social prescribing hub are valued partners.

- Services will maintain close links with and be aligned to GP population-defined and will develop clear links to primary care and other MSK community support services as local primary care models develop.
- To work with colleagues in public health to promote the MSK wellness agenda and come up with innovative models to respond to *worklessness* and in particular enhancing the low back pain pathway. And the Fit for Work Programme.
- To develop informal partnership arrangements to ensure that tier 2 pain services are accessible to the MSK pathway.
- Each GP cluster will have a named MSK lead and GPs will have phone and email access to specialist MSK clinical advice. The provider should work with primary care practices to develop pre-referral criteria for services.

2.7.3 Developing the clinical interface and referral support - The North Kirklees Hub

- Through this specification, clinical assessment and treatment for MSK conditions is rapid, evidence-based, high quality (effective, efficient, equitable, patient-centred, accessible and safe) and comprehensive (e.g. through use of a range of modalities and clinical treatments).
- The provider will establish this MSK hub as a core clinical interface between primary care referrers, the patient and service provision.
- All referrals are expected to be managed through the hub. Unauthorised use of secondary care services will be discouraged, with secondary care providers requested to refer back into the hub if referrals are received erroneously.
- The provider should evidence how they will engage with member practices to ensure referrals from them to this service are maximised while also developing an overall communications strategy
- The CCG is particularly interested in the following model (see figure overleaf). Providers are required to describe their hub solution (noting section overleaf), and demonstrate where efficiencies that can save patients time on their progress through the care pathway could be achieved and the financial efficiencies for the CCG

NORTH KIRKLEES COMMUNITY MSK HUB & INTEGRATED PHYSIOTHERAPY MODEL



- The triage function within the Hub will provide expert opinion, protocol-based triage and provide direct referral for ongoing or alternative care (e.g. care within provider services such as orthopaedic or ?rheumatology opinion, return to primary care, diagnostics, secondary care and integrated care pathways).

- Without being too prescriptive, the role of the Hub should as a minimum include:-

a. Bio Psycho-Social assessment;
b. Conservative Management - optimise pain relief and control and self-care advice;
c. Referral for community based lifestyle services or consideration of the appropriateness of improving access/frequency of physical exercise;
d. Listing for Community / neighbourhood located Physiotherapy, provided by the provider;
e. Direct interface with Orthopaedic Services as a trusted assessor to ensure that appropriate, assessed cases, are listed for surgery to deliver treatment within the current 18 week referral to treatment pathway (excluding diagnostics);
f. It is expected that the Orthopaedic Triage service will ultimately replace the current Direct Access service and specifically include access to extended scope physiotherapists trained to assess and diagnose joint related disorders sufficient to advise GPs on referral pathways into secondary care and include the direct listing of patients for primary replacement surgery.

g. Joint working arrangements will be in place to ensure integrated care planning, co-ordination and seamless delivery across the MSK pathway (including supporting patient choice, GP notification of the pathway process, and effective management of the patient's clinical pathway to support optimal outcomes). This also includes the onward referral for secondary care based opinion or diagnostics on behalf of the referring GPs in accordance with any agreed Clinical Threshold Management pathway.

2.7.4 Developing the Service for our patients

- Services will offer a range of interventions including the provision of information, advice and signposting in relation to referral routes, clinical "hands-on" and "hands-off" treatment, Group therapy interventions, access to approved psychological support (see below) for pain or long term condition dependence, alternative provision and self-management, access to orthopaedic and pain management injections where indicated, and others as defined by best practice and evidence;
- The service should aim for a minimal number of service visits to complete the pathway, monitoring and benchmarking new to follow-up rates;
- The CCG expects most follow up work to be done in either a group clinic or telephone follow up basis;
- A biopsychosocial model of care is desired which should draw on expertise from, and have access to, other specialist clinicians, such as psychology (including e.g. "Improving Access to Psychological Therapies" services), occupational therapy, pain management, rheumatology, neurology, orthopaedics, radiology and others;
- Providers should have a process in place for providing rapid service access to patients who are likely to require continuing advice, guidance or support following assessment and treatment (e.g. through allowing a period of direct access following treatment for appropriate patients where the patient may access the service without a requirement for re-referral). The provider should be able to identify (e.g. through screening) and deal effectively with anxiety and depression associated with such MSK and long-term conditions;
- The provider should develop and agree a pathway for the handling of chronic back pain. The provider should detail a costed pathway that reduces dependency on hospital based support and reduces impact of long term medicines use (especially opiate based prescriptions);
- Referral to Local Authority supported lifestyle services locally should also occur where indicated. Where these have been used elsewhere, providers must detail the benefits gained;
- Where applicable, basic interventions for smoking cessation and weight management should be offered as part of the treatment plan for an individual or group of patients in therapy;
- Patients will be involved in shared decision-making and goal setting and the provider can evidence such approaches; The Provider will engage patients and patient groups to improve knowledge and understanding of the service and receive feedback. This may occur via support groups and/or condition-specific working groups or focus groups;
- Patient Falls - All patients > 65 years asked if their injury/ condition is as a result of a fall, and if they have fallen in the last 6 months. Where there is a confirmed falls risk, patients to be managed in line with local falls pathway(s) including referral into the Local Falls Service;
- The Service Provider will deliver the service with dignity and respect with due regard to both individuality and confidentiality; The service should be appropriate for the requirements of a patient's age, sex, ethnic origin, religion or disability;
- The provider will be expected to adhere to the standards laid out in relevant Safeguarding policies and procedures; the provider is to ensure patients who have relevant disabilities and/or communication difficulties are able to receive the services.

2.7.5 Supporting our GPs and Clusters

- All clinicians operating within the MSK Service (including the hand surgery component) are responsible to the patients' GP who must be liaised with and kept informed on all aspects of care;
- The provider will utilise and respond to e-consultation advice and guidance requests prior to listing a patient for assessment or treatment within the required timescale;
- Referrals will be accepted where patients meet relevant criteria and technology solutions will be used to support effective secure triage and booking;
- The provider will provide a standardised electronic referral access compatible with SystemOne use locally and via E-Referral/Directory of Service provisions;
- Agreed clinical thresholds for service use must be upheld and GPs are supported with the most appropriate clinical advice to aid improving care and referral support to agreed alternative services as required.
- Patients should not be referred back to GPs if there is a solution that the MSK can offer within the scope of the service provided.

2.7.6 Diagnostic support and access

a. The term 'diagnostics' refers to any investigative tests or imaging carried out to aid and support the identification and extent of the patient's condition.
b. The provider will source via CCG contracts any required diagnostics to support the diagnosis and treatment pathways.
c. It is the aim of the commissioner that MSK assessments should be delivered as far as possible in a one-stop model.
d. Diagnostics will include:

- X-Ray;
- Access to pathology, biochemistry, microbiology and haematology;
- MSK ultrasound;
- DEXA;
- MRI

e. The service must be able to access more complex diagnostics including CT, Nerve Conduction Studies/EMG and nuclear medicine. Access to these will be defined by the need of the provider to meet referral to treatment times of a maximum of 8 weeks.
f. The key principles underpinning the provision of diagnostics within the service include:
g. Utilisation of information from any diagnostics test already undertaken during the patient pathway to avoid repetition and duplicated cost;
h. Provision of one-stop access to diagnostic services to inform the diagnosis an'd management plan;
i. Use of diagnostics and imaging services will be in line with national best practice;
j. Maximised use of innovations and technology where evidence based, for example: PACS (Picture Archive and Communication Systems) remote reporting, telemedicine, open architecture MR scanners etc.
k. Where technologies are not available at the commencement of the service, the provider could describe plans to move towards new ways of working during the lifetime of the contract by:-
l. Linking (where possible) of all diagnostics to the appropriate IT systems, particularly PACS and other NHS information systems as required; and
m. Full coordination of any diagnostics delivered (or subcontracts from a third party) with the community service

2.7.7 Permitted Treatments - Clean Room Environment - for Injection Therapy and Hand Surgery

The list below shows a range of treatments identified by the CQC as being appropriate for clean treatment room setting. This is not an exhaustive list and is intended as an indication of possible treatments appropriate for the community service:

- Intra-articular injections;
- Epidurals;
- Manipulation;
- Finger and hand surgery
- Aspiration of knee/joints;
- Nerve root blocks;
- Other minor surgery (to be defined)
- Nail bed surgery

2.7.8 Administration, Leadership and Record Keeping

a. The service will have a named clinical and local management lead responsible for the co-ordination of that team's activity and implementation of common recording systems and delivery standards across the whole service;
b. The service with have a named Senior Responsible Owner/Client Director that is accountable for the service delivery and outcomes achieved.
c. The provider demonstrates clear governance and management structures and processes in optimising patient outcomes and quality service provision. Such structures, processes and outcomes extend to effective workforce planning and training, information governance and clinical governance, for example;
d. A shared electronic record compatible with primary care systems is desired for the services provided; All MSK patients should have a personalised, holistic care plan that is regularly reviewed;
e. The environment of care for direct patient care is clean and compliant with national standards for clinical service delivery.

2.7.9 Clinical Threshold Management and Pathway Development

a. It is expected that the provider will maintain and communicate to stakeholders clear and evidence-based service pathways, communicated in an easy-to-read/ understand format. Such pathways should clearly describe alternative care options, shared care opportunities, self-care alternatives and alternatives to secondary care utilisation as is clinically appropriate for the patient's presentation and assessed referral.

b. The provider will actively promote and engage with the local Mid Yorkshire E-Consultation project and contribute clinical support and advice within SystemOne through national support solutions such as E-Referral as appropriate to that project rollout;

c. The provider will be an active supporter in the development of Clinical Threshold Management solutions, which will ultimately include a resource platform for the storage, dissemination and monitoring of guideline use across North Kirklees (to be provided via the Mid Yorkshire Local Health Economy - to be agreed).

d. Shared Decision Making (SDM) will form a key component that underpins the service. SDM refers to the principle of clinicians and patients working in partnership to agree the preferred treatment from a range of options appropriate to the patient's condition(s). There is a rapidly developing national programme to support this way of working (including a variety of tools to support SDM and relevant training opportunities). The service must fully embrace SDM, operating using this approach, including the use of available tools and ensuring that front-line staff are appropriately trained and competent in this area.

2.7.10 Clinical Communication

a. The provider, and its managed sub contracts, must ensure that appropriate health care records accessible via shared record systems are maintained in line with agreed record keeping standards, including but not restricted to recording changes to clinical presentation – where such could indicate the need for "red flag" referral, or for secondary care intervention, compliance with the prescribed therapy regime or any conflict with other forms of clinical intervention - for example long term condition management.

b. Diagnostics reports that are intended to support shared care or primary care management must be supplied within two weeks of referral for routine requests and 5 working days for urgent requests.

c. The provider will be responsible for ensuring that the referring GP (and patient where appropriate) is issued with an e-discharge summary within a maximum of 3 working days after discharge. Referrers must have access to the pertinent clinical facts via SystemOne access.

d. The e-discharge summary letter must include diagnosis, investigations, and treatment plan and patient/GP advice on further management. If a patient requires onward referral, the discharge letter should provide a clinical reason for this and confirmation whether it has been actioned. "Did not attend" (DNA) details to the referring practice must be issued within 5 working days when a patient does not attend their appointment.

e. There is an expectation that any urgent actions following discharge summary are communicated by direct contact to the referring GP.

f. The provider will use varying communication channels to promote the benefits of the MSK service and integral MSK Hub to ensure maximum take up and support from the GP membership practices.

2.7.11 Workforce Considerations

a. The provider shall ensure that all healthcare professionals and support staff engaged in the triage review, assessment and treatment of patients are appropriated registered and maintain an active registration with the GMC/HPC or other relevant professional body.

b. The provider shall ensure that all healthcare professionals and support staff maintain currency in manual handling and information governance and possess enhanced DRB and have undertaken approved mandatory safeguarding training, including awareness of North Kirklees CCG approved policies and procedures.

c. The provider shall ensure that all healthcare professionals who are involved in performing or assisting in any procedure are competent in resuscitation, able to demonstrate that their skills

are regularly updated, able to demonstrate a continuing sustained level of activity, participate in appraisal of MSK activity, and, participate in supportive educational activities.

d. Providers should ensure that suitable arrangements for the chaperoning of patients, due to request or cultural or heritage need of patients is achievable within the nature of a booked appointment service.

2.8 Development needs/future expectation statement

a. Where appropriate the provider is expected to actively engage in pathway and care threshold development and work flexibly with commissioners, partners, stakeholders, patients and carers to develop services in line with locally agreed priorities.

b. The CCG is exploring the potential to develop a physical location for the MSK Hub by working closely within its Estates Strategy to develop relationships with Kirklees Council. This could provide, over the life time of the contract, present different opportunities for centralisation or colocation and venues for care and therapy to be integrated into the general wellbeing agenda of Kirklees Council.

c. Further opportunities to repatriate physiotherapy services from secondary care where clinically and economically viable will be explored by both the commissioner and provider.

3. Response times and Prioritisation

3.1 Introduction

- The service provider must demonstrate the ability to manage referrals in order to not compromise the referral to treatment target of 18 weeks.

- The provider will operate as an effective part of the NHS North Kirklees CCG and Mid Yorkshire Health Economy and is required to work collaboratively with the commissioner and other health economy providers to provide flexible and responsive support during acute system pressures.

3.2 Defined Response Times and Prioritisation Criteria

The following response times and Prioritisation criteria are:

3.2.1 For all services:-

a. Central managed booking service administrative triage within 24 hours of receipt of referral to be in place after mobilisation (October 2016)

b. Evidence of appropriate GP referrals in line with evidence based pathways and expect to see 20% increase in number of appropriate referrals (by March 2017) from an agreed baseline.

c. Evidence of mechanisms in place to capture patients referred but not ready to progress on their pathway due to e.g. fitness for surgery, controlled existing conditions, weight loss etc. (annual audit - June 2017, 2018)

d. Rapid acceptance or refusal of patients within 48 hours of receipt of referral through clinical triage by mobilisation (October 2016)

e. Patients with MSK-related long-term conditions as recognised on a NHS NK CCG patient primary care list to be given access to telephone or email support, with a response to be provided within 48 hours of any condition-related query by mobilisation (October 2016)

f. Establishment of a GP advice line, via telephone, email/e-consultation via SystemOne or other appropriate method, must be offered to North Kirklees CCG GP referrers. This facility to be up and running by December 2016 for all practices in North Kirklees
g. The advice line must provide responses to any urgent requests for advice within 24 hours and any non-urgent requests for advice within a maximum of 3 working days . This facility to be up and running by December 2016 for all practices in North Kirklees.
h. Access to *My Health Tools* should be provided within all clinic locations to promote self-care options by the end of March 2017.
i. 25% of patients after the first year (September 2017) are on a self-care pathway from an agreed baseline.
j. The provider is to implement an agreed set of patient reported outcome measures that can be used to demonstrate the continued effectiveness of treatment options that captures their view and records progress after each period of clinical intervention (be it a course of injection therapy, a group course of support, a group of patient consultations in a community setting etc.) (in addition - please see section 4.5)A minimum of two training opportunities each calendar year for primary care skills development, for example injection therapy.
k. Appropriateness of referrals, as measured by agreed referral support/clinical thresholds, into the Service on a practice specific basis and numbers of rejected referrals by practice or clinical cluster neighbourhood. This is a clinical audit to be completed and lodged with the commissioner each year (June 2017, 2018).
l. Reduced referrals to secondary care due to Hub assessment and community or shared decision making alternatives being implemented by the end of March 2017. Assessed with reference to contract start baseline.
m. Diagnostics undertaken and reported, including feedback to patient, within 2 weeks of request.
n. Patients requiring onward referral for surgical intervention must be referred by no later than the end of the 12th week of their RTT pathway
o. Adherence to all national Waiting Time targets as detailed in NHS Planning Guidance.

3.2.2 For Physiotherapy services (to be reported at the end of each quarter commencing January 2017):

a. New to Follow Up ratio of less than 1:3
b. 50% (in year 1) of follow up care provided through telephone assessment or group interventions from an agreed baseline.
c. Greater than 95% of patients triaged within 48 hours of receipt of referral
d. Greater than 95% of all urgent patients seen within 5 working days of contacting the service (unless national guidelines specify otherwise, in which case national guidelines must be adhered to).
e. Greater than 90% of non-urgent patients seen for their first appointment within 20 working days of contacting the service. (Unless national guidelines specify otherwise, in which case national guidelines must be adhered to).

3.2.3 Prescribing and Medicines Management:

a. The CCG requires the provider to adhere to and implement CCG prescribing guidelines and commissioning policies for medicines.
b. The contract costs includes the full cost of any medicines that would be administered as part of the service with the exception of excluded from tariff high cost drugs as set out in Monitor annual guidance.
c. The service provider will be expected to either supply or prescribe any medicines that are required for immediate or urgent use (i.e. required to start within 14 days of any face to face or telephone consultation) within the tariffs for the service or medication required as part of a treatment pathway managed by the service provider.

d. Non-urgent requests for medication to be commenced (e.g. for patients to be discharged from the service) may be made directly to the patients GP through an agreed electronic format; the expectation is that the service will **not** use patients to convey messages.

e. The provider is expected to seek prior authorisation from the CCG before introducing new medicines or other prescribed items (e.g. devices) into the local health economy.

3.3 Specific requirements for Hand Surgery

The provider will either provide itself or via a sub contract or joint venture arrangement a community based surgical service for the treatment of:

- Carpal Tunnel Decompression
- Excision of Hand/Wrist Ganglions causing Nerve Compression/Entrapment
- Removal of solid lumps of the hand
- Golfers/Tennis Elbow Release
- Dupuytren's Fasciectomy/Fasciotomy

3.3.1 The service should consist of:

a. confirmation of clinical diagnosis
b. pre-operative assessment
c. surgical treatment
d. discharge with comprehensive patient information on self-care and signs of possible post-operative complications.
e. Fast track access for post-operative complications.
f. Based on clinical judgement, there may be occasion where post-operative follow-up is clinically indicated; it is anticipated, however, that the number of face-to-face follow-ups will be kept to a minimum.
g. Feedback to patient and referring clinician of any histology or other results (if applicable
h. Nerve Conduction Studies should be an integral part of this service. All nerve conduction studies must be carried out and reported by qualified and skilled neurophysiology personnel. All reporting should be performed by a consultant neurophysiologist or Allied Health Professional who has been trained to the appropriate standard.
i. The type of Test Device to be used is not prescriptive, however, it is the provider's responsibility to ensure that any such device is safe, fit for purpose, and recognised by the Department of Health/Relevant National Health Body as a recognised diagnostic device. Evidence of this will be required during the accreditation process.

3.3.2 Other referral criteria should include:

- Patients present with significant symptoms and/or functional impairment
- Must be a history of paraesthesiae or pain in the median nerve distribution with regular night wakening
- The patient is fit, willing and able to proceed to surgery

3.3.3 Examination must reveal any of the following features:-

- Reduced or altered sensation in median nerve distribution
- Wasting of abductor pollicis brevis
- Positive Tinel's sign
- Positive pressure test
- Positive Phalen's test
- Relief from steroid injection into the carpal tunnel strongly supports the diagnosis

3.3.4 The service will communicate with referrers in a supportive manner in order to :-

To provide advice and support to local practitioners by telephone by e-consultation through SystemOne (provided that local NHS networks are secure) as required to assist with the management of patients.

To report and advise the patients General Practitioner and/or referring clinician of the assessment, treatment and outcome of the patient's episode of care. Patients should be given the choice of whether they require a copy of any communication relating to their episode of care.

3.4 Improved Accessibility

Accessibility refers to the following:

- Access - waiting times, e.g. reduction in variation for waiting for access to diagnostics and appointments or treatment
- Access – location (e.g. community or secondary care provision of the service) and physical environment (e.g. patients not expected to cross multiple organisations for one pathway)
- Access – to administrative support to pathways such as booking/amending/cancelling appointments and responsive systems in place to support this
- Access – to innovative cost effective ways of seeing patients appropriate to their needs and wants (e.g. telephone consultations and use of technology to support consultation/dialogue)

3.5 Handling Urgent Need

Urgent and routine criteria should be maintained by the provider and agreed with providers of specialist orthopaedic and rheumatology services (e.g. secondary care) and through partners to the Care Closer to Home agreement. Urgent criteria should include as a minimum:

- Acute uncontrolled pain,
- conditions causing severe disruption to lifestyle,
- patients with a carer who is unable to care due to the presenting condition,
- acute severe neurological changes and
- Patients unable to return to work due to their presenting acute condition.

3.6 Defining Treatment Requirements

Position statement - the commissioner expects that there will be reducing follow up rates handled in a face to face manner - technology -including telephone and email follow up and group sessions must be designed into your service offer.

a. MSK Physiotherapy

Treatment delivered within first and follow-up appointments should include:

- Exercises (as an individual or in groups)
- Mobilisations, massage and manipulations
- Relaxation strategies
- Acupuncture (a small amount – on an ad hoc basis; no dedicated clinics)
- Electrotherapy
- Injection therapy – regular sessions
- Hydrotherapy

- Consideration of referral option to a chiropractor at the patients expense pending the option to determine an invest to save business case as a service development.

b. Orthopaedic Referral Support and Treatment (for hips, knees (including anterior knee for patients aged 18 years and above) and shoulders) and Hand Surgery

Treatment delivered within first and follow-up appointments should include:

- Patient education - Understanding of symptoms
- An opinion and explanation on diagnosis and prognosis
- Appropriate investigations and referrals
- Consideration of the Directory of Service options with the patient to support choice as a trusted assessor and suitable direct listing for simple primary replacement surgery where appropriate pathways have been secured with secondary care providers and/or the local health economy's Clinical Threshold Management project.
- A discussion about the choices and options, risks and benefits for treatment
- A discussion on lifestyle modifiers and brief intervention strategies for smoking cessation and weight management
- A choice of non-surgical interventions including joint and soft tissue injection
- Expert physiotherapy opinion and treatment plan monitoring
- Access to specialist advice and information about the risks and benefits on a range of non-surgical treatments
- Access to community exercise and lifestyle programmes

3.7 MSK Hub assessment responsibilities

a. Initial triage and telephone assessment
b. Consideration of the Directory of Service options with the patient to support choice as a trusted assessor and suitable direct listing for simple primary replacement surgery where appropriate pathways have been secured with secondary care providers and/or the local health economy's Clinical Threshold Management project.
c. A discussion about the choices and options, risks and benefits for treatment
d. A discussion on lifestyle modifiers and brief intervention strategies for smoking cessation and weight management
e. Patient interview and assessment including medication review with the aim to reduce dependence on pharma based treatments as a first line treatment
f. Monitoring of the agreed treatment plan
g. Review and monitoring of compliance
h. Access to biosocial and psychological support
i. Access to appropriate physiotherapy input
j. Access to the tier 2 pain service

3.8 Population covered

a. The Musculoskeletal service will deliver a high quality, comprehensive, patient focused service for the GP registered population of North Kirklees CCG who are over 18 years of age.
b. The service will also need to make appropriate provision for local patients who are travellers or have no fixed address.

3.9 Operating Hours

As a minimum, the provision of services will be through the following operating hours available for patient access and care:

- Five days per week (Monday to Friday) and open for consultation 52 weeks per year for a minimum access of 40 hours per week on a sessional basis. Opening hours must include at least two evenings per week per location. There is no requirement for a service to operate on Bank Holidays.

- The provider will ensure that some services are provided outside core general practice hours (8:30 – 6:30) in line with GP Extended Access and national initiatives for weekend and extended care hours. Opening hours should follow patterns in demand to keep waiting times low.

3.10 Acceptance and exclusion criteria and thresholds

Acceptance criteria	Exclusion criteria
Patients aged 18 and over where appropriate following triage Registered with a North Kirklees CCG GP (the Service will also need to make appropriate provision for local patients who are travellers or have no fixed address) Appropriate for referral as defined by assessment; This may include transfers of care from other providers	Patients not registered with North Kirklees CCG GP Patients aged under 18 years of age Patients requiring emergency treatment or assessment not suitable for Orthopaedic Triage or MSK Physiotherapy e.g. cauda equina syndrome, patients with suspected sepsis arthritis. Patients with suspected cancer Patients with post-operative or post traumatic complications Inpatient MSK procedures Regular fallers (over the age of 65 years of age) unless referred for advice from the Falls Service Patients requiring general anaesthetic for an inpatient procedure Specialist commissioning services Acute and violent trauma (e.g. RTA of fall from a significant height)

The following indications should be referred directly to the Rheumatologist in Secondary Care –

- Suspected Inflammatory Arthritis (including Rheumatoid Arthritis, Sero negative arthritis, severe gout)
- Suspected multi system inflammatory disease (including vasculitis and connective tissue disease)

Widespread neurology with or without upper motor neurone signs

Patients with red flag symptoms. ('Red flag' symptom is the term given to the identification of dangerous or potentially dangerous findings in the history or examination. These patients should be referred directly to secondary care with appropriate direct liaison with secondary services)

Non-MSK physiotherapy (for example neuro-rehabilitation)

Patients with the following conditions will be excluded from the service

- Immediate life threatening conditions;
  - Suspected cancers;
  - Acute trauma, e.g. RTA or falls from a significant height, still in the acute phase;
  - Non-mechanical pain: constant, progressive, not related to posture/activity;
  - Patient with red flag symptoms, e.g. cauda equine, systemically unwell, significant weight loss, suggestions of serious infection or malignancy;
  - Widespread neurology with or without upper motor neurone signs;

- Post-fracture patients.

In addition, any service or activity related to any service that the provider wishes to provide and is not contained within this service specification will not be funded by the commissioner unless agreed with the commissioner in advance. Where the commissioner wishes to de-commission any service contained within this specification, this will be in accordance with the agreed terms of the contract.

These exclusions will be reviewed on a bi-annual basis.

3.11 Interdependence with other services/providers

a. The expectation of the service is that it will be delivered to patients in an integrated, coordinated and cohesive manner.
b. The CCG encourages providers to work collaboratively with stakeholders in the Mid Yorkshire local health economy.
c. The provider must promote its services within the local health economy Directory of service
d. The provider must promote its triage and assessment processes to secondary or other choice providers where direct listing is to be exercised in order that the trusted assessor role is acknowledged.
e. Consideration of the Directory of Service options with the patient to support choice as a trusted assessor and suitable direct listing for simple primary replacement surgery where appropriate pathways have been secured with secondary care providers and/or the local health economy's Clinical Threshold Management project
f. Any sub-contractors must be suitably registered with the CQC
g. The CCG expects close working and engagement with current contractors that are party to this arrangement, in particular Pain Management Solutions Ltd until December 2017 and Locala as the Care Closer to Home provider across Huddersfield, Calderdale and North Kirklees (for podiatry services).
h. It is expected that the provider of this service will work with local primary care providers, secondary care providers, other providers and stakeholders across public, independent and third sectors to optimise outcomes for patients.
i. The provider will be expected to demonstrate their pathways of care as part of the commissioned service offer. The CCG expects the provider to work closely with providers of orthopaedic services to NHS patients so that there is the opportunity to streamline patient care into secondary care services (for example through "direct listing" from within the integrated service).
j. For any diabetic patient being followed up by the Mid Yorkshire multidisciplinary team and pathway, relevant clinical relevant information must be shared to maximise the care received from that overall care approach.

3.12 Position Statement on Group treatment options

a. The Commissioner is keen to develop group therapy support for patients and would therefore like to see proposals on undertaking the following services on a group basis MSK Physiotherapy patients on a weekly basis.

b. Class types:

- **Anterior Cruciate Ligament Classes:** maximum 8 per class - fortnightly - for 8 weeks
- **Back 2 Fitness:** weekly 1 hour in duration, maximum 8 people participate for 8 weeks.
- **Back pain care and support** – as above
- **Pilates/Core Stability:** Once a week for 6 weeks, 1 hour duration for 8 people
- **Lower Limb:** Offered twice a week, 1 hour in duration, 8 sessions attended, maximum of 8 people participating in each of the sessions.
- **Hydrotherapy:** Pool to be accessed monthly??, maximum 6 people for a period of 6 weeks. **The Commissioner does not currently have this provision available.**

c. Patient self-management is encouraged wherever possible - particularly in the area of life style modifiers, including obesity management, dietary advice and improving access and benefit from physical exercise.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The service should be provided within the key principles of the NHS and will operate according to key standards and NICE guidance.

The provider's premises should meet standards as specified by the Department of Health.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges and professional associations, including the British Association of Hand Surgery)

a. Operative procedures should be undertaken by Orthopaedic surgeons or General Practitioners with a special interest and appropriately trained in hand surgery.

b. **Operating Facilities – principal statement**- A number of factors may be involved in post-surgical wound infection and little is written on infection risks that occur from surgery carried out in general practice. However, the principles of asepsis apply to both primary and secondary care settings.

c. **The room** should be of sufficient size to allow staff and patients to move around freely (recommended floor area of approximately 17.5 metres^2). A clinical hand washbasin should be available. The room should contain the minimum amount of equipment to allow staff to work unhindered. The furniture, fixtures and fittings should be clean and in a good state of repair. A separate sink for cleaning should also be available.

d. **Organisation** of the clinical area should be such that the areas for clean and dirty procedures are clearly defined and arranged to reduce the risk of cross contamination, 'clean' and 'dirty' activities should be effectively separated ideally into separate rooms.

e. **Flooring** should be of sheet vinyl with welded seams, this construction will allow for ease of cleaning. Floors should be cleaned at least daily using detergent and water; this should preferably take place at the end of the day or session. Blood splashes should be removed as soon as possible

f. **Walls** should be smooth and washable, preferably be painted using an oil-based 'egg shell' finish paint; this type of paint allows walls to be washed easily. Walls only need to be cleaned when visibly soiled (usually every 6 months) by using detergent and water. Blood splashes should be removed as soon as possible

g. **Lighting** should be of a suitable construction that allows easy cleaning and does not allow a build-up of dust. It should be cleaned at the end of each day using detergent and water.

h. **Mechanical ventilation** should be available. The minimum standard being an electric extractor fan. The fan should be inspected on a monthly basis and cleaned on a 3 monthly basis to prevent the build-up of dust. Windows must not be opened during surgery. More effective air handling should be considered if more complex surgical procedures are to be undertaken.

i. **Central heating radiators** can quickly build up high levels of dust so it is important that they are cleaned on a regular basis. Radiators should be painted with oil based 'egg shell' finish paint.

j. **Fixtures and fittings** must be in good condition and easily cleaned. Curtains should be avoided where minor surgery is carried out. If present, they should be washed on a regular basis (usually every 6 months) or when visibly soiled. Vertical blinds are more appropriate at windows than curtains. Disposable paper sheeting should be used for examination and operating couches.

k. **A nurse call system** should be available for those patients who may feel unwell after having undergone minor surgical procedures and may be left unattended.

l. **Surgical instruments** should, ideally, be provided by a Sterile Supplies Department. If this is not possible, a high quality system for cleaning and autoclaving must be provided in-house**.** There must be adequate space for storage of instruments.

m. **Suction container** liners should be disposable and disposed of as clinical waste. Suction tubing should be disposable and the manufacturers will specify if it is single use. If reusable jars are used the contents of the jar should be discarded carefully into a sluice or toilet to avoid the production of aerosols. The jar should be decontaminated and stored dry. Eye protection may be required when carrying out this procedure.

n. **Surgical hand disinfection** is essential for the prevention of surgical wound infection. A hand washbasin separate from that used for the washing of instruments should be provided. The basin should be fitted with a mixer tap, elbow operated. Adjacent to the basin should be liquid soap/ antiseptic detergent dispensers, disposable paper towels and alcohol hand rub/gel. Reusable towels must not be used.

o. **Patients' skin sites** should be disinfected prior to surgery. The aim is to remove transient bacteria and reduce the number of resident bacteria. The preparation used should be fast

acting and have a prolonged antibacterial effect. Alcoholic solutions of 0.5% chlorhexidine, povidone-iodine 7.5% or 0.5% triclosan are most frequently used. Skin reactions may occur with some products.

p. The solution should be liberally applied to the operation site and surrounding area and then allowed to dry. Skin disinfection should be carried out immediately prior to surgery. Hair removal is not always necessary, if required use a depilatory cream or electric clippers rather than a razor to avoid trauma, which increases the risk of post-operative infection.

q. **Protective clothing** is worn by those carrying out minor surgical procedures to protect themselves and the patient from infection. A new disposable plastic apron should be worn for each patient. Sterile latex gloves should be used for any minor surgical procedure involving contact with normally sterile areas of the body. Eye protection should be worn if splashing is anticipated. After use protective clothing should be disposed of as clinical waste.

r. **Clinical waste** should be placed in a foot operated waste bin. Yellow clinical waste bags should be removed at the end of each session/day and placed in a secure designated holding area for clinical waste. The foot-operated bin should be cleaned at least weekly using detergent and water.

s. **Records** must be maintained using an operations register, both for audit purposes and as a safeguard for medico-legal reasons. It should include details of the date and time of operation, patient's name and address, names of surgeon, procedure performed, if local anaesthetic was administered, name of assistant and whether histology or other specimens were sent. FHSA or NHS Business Services Claims forms are not adequate for this purpose.

t. **Contracts** should be in place to ensure the above standards are met, including maintenance of equipment, disposal of waste and housekeeping.

4.3 CLINICAL AUDIT REQUIRMENTS

The provider will be required to report on clinical outcomes and quality of service provision including:

- Review of Surgical conversion rates after first programme of physiotherapy intervention
- For Hand Surgery - wound dehiscence rate, infection rate.
- Follow-up rate and reasons for this
- Number of repeat Nerve Conduction Studies and why these were carried out (this includes those nerve conduction studies provided by the referring practitioner with a referral).
- A review after the first 6 months of reported Significant Incidents of all types and an audit of remedial actions

The first audit will be required within 9 months after the commencement date of the service (by June 2017,2018).

4.4 PATIENT SATISFACTION

a. The service provided must include a Patient Specific Function Scale to capture patient outcomes. This could be through the use of Boston Questionnaire before & after **OR** Patient Global Improvement Index.

b. A summary of formal complaints and their outcomes should be included by the end of the first quarter of the following financial year end (i.e. for the Financial Year 2016/17, this data should be reported to the Commissioner by the end of June 2017).

c. Specifically note the requirements for patient reported outcomes and its relevance to overall patient satisfaction.

4.5 Positive Patient Outcomes

a. Most MSK services are used to collecting some form of outcome data but are not necessarily using it to the greatest effect. This is evident from the Right Care benchmarking of MSK services across West Yorkshire (January 2016)

b. It is vitally important that there is a link between processes and outcomes. By understanding the steps involved with developing an outcome-focused service, it is possible to create pathways to provide the data required. Clinical and process outcomes can be used to ensure a baseline standard in quality across the service. This becomes particularly important when multiple sites and practitioners are involved in delivering one service, which will be the case for the service

c. Examples of outcomes measures used across the MSK pathway include the hip and knee PROMS

d. Expected outcomes include, but are not limited to:
   - Evidence of reduction in unnecessary and inappropriate referrals to secondary care
   - Self reported outcomes on service experience
   - Self reported outcomes of the impact on the patient's quality of life from the onset of treatment post assessment and in a staged way commensurate with the treatment pathway selected until discharge.
   - Evidence of health promotion, prevention, self-management and self-care and demonstrating improvements in these areas over time
   - Evidence of utilization of the *MyHealthTools* App
   - Improved clinical outcomes (over agreed times) and evidence of patients satisfaction
   - Evidence of a positive patient experience through integrated access to community, primary and secondary care services
   - Increased use of one-stop clinics to minimise re-attendance of care types that could have been anticipated and delivered by a single visit

e. By the end of the first year of the contract (September 2017), 85% of patients must have a measured patient outcomes included, rising to 95% by the end of the second year (September 2018).

5.	Location of Provider Premises

a. The Provider is to supply full address details for suggested premises which should be within the Kirklees local authority area for the effective operation of the services as specified;
b. The cost of the provision of suitable accommodation is to be bourn by the provider. Opportunities to explore the potential benefits of existing accommodation and lease terms should be ascertained by providers from NHS Property Services or independent property management agents as appropriate.
c. The CCG would wish to discuss options for the mobilisation of the suggested four community physiotherapy bases as part of the mobilisation phase for the preferred bidder. Allowance should be made for such rental of accommodation in the proposal.
d. The CCG will not be liable for increased costs of accommodation provision.
e. The Provider is to supply details of how it proposes to establish the MSK hub in order to maximize the opportunity to make it a clinically supportive triage service. This could be achieved virtually or physically within the North Kirklees area.

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