**MUSCULOSKELETAL (MSK) SERVICE**

**NHS NORTH WEST LONDON INTEGRATED CARE SYSTEM (NWL ICS)**

**Service Specification**

**V11.2 (DRAFT)**

**NWL Draft Specification v11.2**

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Appendix A: National Guidelines, Policies, Tools

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| **Service Specification No.** |  |
| **Service** | **NWL Integrated Musculoskeletal Clinical Assessment and Treatment Service.** |
| **Commissioner Lead** | Tbc |
| **Provider Lead** | Tbc |
| **Period** | Tbc |
| **Date of Review** | Tbc |

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| **1. Population Needs** |
| * 1. **National/local context and evidence base**   There is considerable variation in provision of MSK services between the 8 boroughs of North West London (NWL) Integrated Care Board (ICB), resulting in inequality of access to evidence-based intervention and significant variation in prescribing and surgical rates along with unequal waiting times. The burden of long-term MSK condition is also expected to vary, based on socio-economic variation between regions.  The key challenge for North West London is how best to manage growing demand for Musculoskeletal (MSK) services (namely, Orthopaedics, Pain Management and Rheumatology) and to deliver consistent access to evidence-based standards of MSK care for patients across NWL which maximise patient outcomes and experience.  The current Model of Care contributes to unsustainable referral rates and consequent sub-optimal waiting times and does not support General Practice to, in turn, support patients to self-care. Collectively, these factors contribute to high secondary care outpatient activity with consequent sub-optimal surgical conversion rates and Referral-to-Treatment (RTT) waits. |
| **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** | **Y** | | **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** | **Y** | | **Domain 4** | **Ensuring people have a positive experience of care** | **Y** | | **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** | **Y** |   **2.2 Local defined outcomes**  The Provider is expected to provide a service to all patients aged 16 and over registered with a North West London GP practice. As described in the guiding principles, the Service should ensure patients’ holistic needs are identified as part of their MSK assessment, with signposting to the range of services available in primary and community settings to provide physical activity, emotional and occupational support, as well as a focus on personalised care planning for those with long-term MSK conditions.  In addition to providing self-care support, the Provider is expected to provide a Service that delivers a range of treatment interventions in the community, with robust use of shared decision-making and a focus on personalised care. This Service should focus on improving outcomes from surgical and non-surgical care, optimising the use and interpretation of diagnostics as well as referrals to Secondary Care, whilst supporting workforce learning and development across the system. Focus on these areas should improve both patient experience and Referral to Treatment (RTT) times in secondary care.  **Guiding principles:**   * Providing a holistic, evidence-based continuum of care for patients with MSK presentations and ensuring they are provided with standardised information and seen at the right time in the right place, according to locally agreed pathways. Low value over-diagnosis and over-treatment should be addressed, whilst improving access for appropriate patients to evidence-based specialist interventions. * Through shared decision-making, provide support to patients to manage fitness, physical health and mental wellbeing, with education around optimisation of long-term conditions. This would include the use of social prescribing, peer support, third-sector involvement, support to remain or return to work and recognition and support of mental health needs. * To provide a range of diagnostic and treatment options for patients in their communities, expanding the advanced practitioner workforce and psychologically-informed practice amongst health professionals, whilst working collaboratively with local specialist colleagues. This will allow the ICB to build up a resilient local portfolio of treatment options outside of the acute trust for patients to choose and to support system recovery and secondary care demand. * Partnership working across the MSK landscape, including both NHS and third-sector organisations, as well as with the ICB and patient partnerships to design, evaluate and improve service provision, with continuous quality improvement based on patient reported outcome and experience data. |
| **SCOPE**  **3.1 Aims and objectives of the Service**  NWL ICB will commission a clinically led multi-disciplinary community based MSK clinical assessment and treatment service (the “Service”) for their adult and young adult (16+) GP registered population, standardised across boroughs. The Service will provide multi-disciplinary team (MDT) MSK care including triage, assessment, diagnosis, treatment and care planning for patients with MSK conditions. The Service will support NWL ICS strategic commissioning intentions to ensure that high-quality care is delivered in the appropriate setting, supporting primary care, system recovery and maximising population outcomes.  The population covered will include all patients registered with an NWL ICB member practice and all patients temporarily registered with an NWL ICB member practice.  The specialties included within the Service scope are:  • Level 1 MSK physiotherapist-led and MSK podiatry services  • Level 2 orthopaedic and spinal services;  • Level 2 rheumatology services; and  • Level 2 pain services  Definitions:  Level 1 Service: Physiotherapy-led assessment and treatment  Level 2 Service: Specialist-led assessment and treatment  **3.1.1 Aims & Objectives**   * **Integrated care pathway with partnership working and a single point of access**   + A digitally and clinically integrated service, with strong relationships and partnerships between clinical staff across MSK disciplines and health sectors; for example, primary care, secondary care, as well as other community services (such as mental health) and also third sector voluntary organisations.   + A single point of access with a central booking system. This may also incorporate digital triage and patient education tools.   + Triage from a standardised minimum data set referral form, or patient self-referral, should direct patients to physical therapies, orthopaedic, spinal, rheumatology and specialist pain input, ensuring patients are seen in the appropriate setting of care according to local clinical pathways. The Service will act as a gatekeeper for all elective GP referrals to orthopaedic, spinal, rheumatology and pain services in NWL.   + Robust assessment should identify serious underlying pathology and those patients appropriate for specialist treatment.   + Utilise, evaluate and contribute to the NWL ICS agreed clinical pathway guidance when triaging referrals and providing advice to primary care clinicians on the management of patients with MSK conditions.   + Ensure that the most appropriate community-based treatment is offered based on clinical need, but where secondary care intervention is required; appropriate benchmarking is monitored to ensure appropriate patients are referred for secondary care input (considering the NHSE GIRFT reports and current NHSE MSK benchmarks).   + An integrated seamless care pathway should improve quality and efficiency of service delivery, reducing unnecessary secondary care and diagnostic utilisation and improving patient experience. * **High-value, patient-centred, evidence-based MSK care**   + High-quality patient-centred assessment of MSK conditions, education and treatment, through shared decision-making, based on clinical need and patient preferences, whilst aligned to best evidence, national guidelines and locally agreed clinical pathways.   + Psychologically-informed practice, empowering patients to understand their condition, through evidence-based messaging and education, as well as any individual biopsychosocial contributors, to improve their ability to self-manage musculoskeletal conditions.   + Long-term condition management should focus on a holistic whole-person approach, revolving around shared decision-making across an evidence-based range of management options and individualised personalised care planning.   + The Service should focus on addressing low-value (ineffective, costly or harmful) over-diagnosis and over-treatment of musculoskeletal conditions, whilst ensuring appropriate patients, likely to benefit from further evidence-based interventions, are referred to specialist input either within the Service or secondary care settings (with direct-listing where possible) in a timely manner. * **Personalised, self-management support**    + Promotion of long-term condition management for chronic MSK conditions, with a focus on quality of life, i.e. function, emotional well-being, social functioning, every activities and return to work.   + Patients should be provided a range of appropriate treatment approaches and support to manage their condition within primary and community settings.   + Reduce the risk of co-morbidities associated with all MSK pain such as depression, social isolation and loss of employment and other disability.   + Provision and development of health and wellbeing coaches and social prescribing link workers, along with partnership working with mental health services.   + Improving service user-centred clinical care through co-production of service design and delivery, and through implementation of the NHS England six pillars of personalised care to provide the appropriate support and management of MSK conditions in line with evidence and national best practice guidance.   + Disseminating knowledge about disability rights, statutory benefits, workplace benefits, home adaptations, and support for travel and transport to promote quality of life and independence.   + Signposting towards national and local charities and community groups for further information and peer support.   + Addressing health inequalities, through appropriate interpretation services, providing information in a range of languages and accessible formats; mitigating against inequality through digital exclusion or low health literacy, and monitoring service access to underserved groups including by age, ethnicity and deprivation.   + Leading partnership working with local PCNs and specialist providers to embed personalised care into clinical pathways, including NHS England (and other) decision support tools, ensuring staff receive training on personalisation of care and that this is regularly audited through patient feedback and standardised measures.   + Engaging with and supporting PCN-based social prescribing link workers, health and wellbeing coaches and other PCN staff (including GPs) to provide ongoing person-centred support for people with chronic and complex MSK symptoms that are unlikely to benefit from additional input from specialist services. * **Equality of accessible care**    + Timely and easy access to telephone, video and face-to-face consultation, based on patient choice, need and risk.   + Care should be delivered out of several borough-based sites which provide an equality of access geographically across NWL and offering appropriate hours and ease of access.   + The Service should seek appropriate engagement with patient partners / lived experienced partners from key under-served groups and communities. * **Population health management and system recovery**    + The Service should work with the ICS to identify areas of variation (at primary, community and secondary care levels) to reduce inequalities (for example through the Core20PLUS5 approach to drive targeted action) in access to effective services and best establish ‘value’ across the MSK health economy.   + Enhance the management of patients within primary and community care, and actively manage the demand for secondary care services ensuring patients have quicker access to appropriate treatment in the appropriate setting.   + Ensure that there is no delay towards the achievement of the treatment target maximum waiting time from GP referral to definitive treatment.   + Implementation of KPIs which address system health utilisation, patient clinical outcome and patient experience measures. * **Workforce development**    + Workforce development and integration is a priority, with advanced practitioner capacity being key to relieving system pressures, whilst also developing primary care and providing clinical integration throughout primary, community and secondary care settings.   + Task-shifting from secondary care orthopaedic, spinal, rheumatology and pain services, as well as primary care support, requires the development of a significant workforce of advanced physiotherapist practitioners with adequate resilience for surge planning.   + The Service should build on skills and confidence of primary care in MSK assessment, diagnosis and management, for example through primary care-based MDTs, as well as supporting recruitment and implementation of First Contact Practitioner roles. * **Innovation and evaluation**   + Appropriate data collection, analytics and reporting for required local and national datasets, as well as evaluation of opportunities for quality improvement, evidencing the ‘value’ of services.   + The Service should undertake continual review to identify variation within the Service and provide appropriate mentorship and development to mitigate the gap between evidence and clinical practice within musculoskeletal care.   + Partnership working with academic institutes will encourage robust analysis of the large datasets available and answer questions around clinical and cost-effectiveness of service delivery. |
| **3.2 Service description/care pathway**  The Service will provide triage, assessment, diagnosis, treatment and care planning for adult patients of 16 years and above. (All referrals for 16 years and above will be triaged by the Service. For younger adults (16 – 18 years old) those requiring paediatric assessment or management may need to be rapidly directed to the appropriate paediatric services, if clinically necessary).  The Service must be delivered by a clinically led, for example, Consultant Physiotherapist, GPwER (GP with extended role), or Consultant Physician) multidisciplinary team, including a combination of workforce skills, including roles such as.   * Consultant Physiotherapists and Advanced Physiotherapist Practitioners * GPs with extended roles in MSK, sports medicine, rheumatology and persistent pain * Physiotherapists * Podiatrists * Clinical Psychologists and Health Coaches * Specialist Nurses * Occupational Therapists * Pharmacists * Consultants (including sports and exercise medicine, pain management, trauma & orthopaedics and rheumatology), * Sports and exercise and fitness practitioners * Rehabilitation assistants and technical instructors * Administrative input, IT support   In order to ensure end-to-end system integration, specialist consultant input from local secondary care sites using service-level agreement arrangements should be integrated directly.  **3.2.1 Included pathways and conditions**  The Service shall treat the following conditions (not an exhaustive list):   * Arthralgia (eg osteoarthritis), myalgia (small and large joint, soft tissue, muscular pain). * Spinal pain. * Chronic regional or widespread MSK pain (e.g. Fibromyalgia). * MSK related soft tissue lesions (e.g., tendon injuries, ganglion, Dupytrens contracture, trigger finger). * Metabolic bone disorders (e.g., Osteoporosis). * Peripheral nerve entrapments (e.g., carpal tunnel syndrome). * Sports Injuries.  **Exclusions**  * Patients under the age of 16 * Patients not registered with a GP in the commissioning boroughs (unless a non-contractual agreement is in place). * Patients requiring home visits (non-ambulatory patients typically have different and wider needs beyond that provided within Level 1 and 2 MSK interface services; this rehab is best placed by community-based teams with physiotherapy integrated with occupational therapy, district nursing as well as social work teams to address all areas of frailty and re-enablement). * NHS England Prescribed Specialist Commissioning Services * Non-MSK podiatry   Clinical practice should be delivered in line with national guidance (including that from NICE, NHSE BestMSK, GIRFT, NHS Evidence Based Interventions, Choosing Wisely, etc) which would be reviewed and appropriately incorporated into locally agreed pathways, taking into consideration local needs and services. Appendix A highlights some national best practice guidelines. |
| **3.3 Care pathway**  **3.3.1 DIAGRAM**  **Timeline  Description automatically generated with medium confidence**  As highlighted, the pathway is not linear, with the majority of patients being supported outside of hospital with appropriate input where required from primary and community-based assets. The direct self-referral single point of access should provide a route to community-based care to all patients regardless of the setting they are being seen in. |
| **3.3.2 Partnership Working** Provider collaborative and place-based partnerships will be essential for efficient use of resources, maximising quality and patient experience, driving innovation, as well as to tailor care for each geographical region. The provider should work collaboratively within a formal governance structure to deliver the service specification and an integrated pathway from primary to secondary care.  Examples of such partnerships include primary care networks / federations, third sector organisations, other NHS community services (such as mental health), diagnostic services, as well as secondary care specialist services including orthopaedics, rheumatology and pain services.  The provider should work with existing Sports Medicine consultants and trainees within NWL to best utilise this resource, particularly in the context of acute injuries.  An ideal framework would include an over-arching North West London MSK provider board, with key stakeholders, engaged with NWL ICB. Relevant related governance committees within the NWL for decision-making include the North West London MSK Network, North West London Clinical Reference Groups (orthopaedic, rheumatology, pain and musculoskeletal radiology) as well as relevant local care teams. In addition, public involvement in the Provider’s Boards.   **3.3.3 Workforce** Workforce development will be a key priority for the Service, including physical therapists, but in particular, senior physiotherapists and advanced practitioners, as well as providing opportunities for training of staff roles in primary care across NWL.  The workforce should have a minimum level of competency in psychological-informed clinical practice, for example, approaches such as acceptance commitment therapy and/or cognitive behavioural therapy. A number of practitioners with advanced postgraduate training in psychological skills within the Service would be beneficial for more complex cases.  Adequate supervision and safety netting should be in place to mitigate risks when working with more complex patients.  Development of the advanced practitioner workforce will be critical to provide additional scalable specialist capacity for all branches of MSK activity across the sector, including orthopaedics, rheumatology and pain. These secondary care services will increasingly rely upon an advanced practitioner workforce in order to meet ongoing demand and waiting list targets.  An approximate minimum estimation would be to have 5-6 Band 6/7 practitioners and 3-4 advanced practitioners for every 10,000 annual referrals into the MSK Service.  In view of the pressures to fill advanced practitioner roles, appropriate quality assurance should be provided to NWL ICB in terms of experience and expertise of staff in such complex roles.  Rotation of practitioners through other settings will be key for clinical integration, relationship building and professional development. Community practitioners should rotate through secondary care specialist departments as well as secondary care based MDTs, through honorary contracts, as well as through primary care through FCP roles.  Multi-disciplinary team (MDT) working will be essential for effective delivery of the Service. This will require service-level agreements with clinicians across local providers, particularly from specialist settings such as orthopaedics, rheumatology and pain medicine. SLAs with specialist staff from local NWL Secondary Care Trusts will be essential to deliver clinical integration across the pathway. The Service will be expected to host a range of expertise within the Service, such as physiotherapists, advanced physiotherapist practitioners, sports and exercise therapists, GPs with extended role, sports & exercise medicine specialists, orthopaedic surgeons, rheumatologists, pain specialists, MSK radiologists, psychologists, health coaches and link workers. There should be integrated educational training days and regular MDT case based discussions to improve clinical knowledge supported by all NWL services.  The Service should facilitate educational opportunities for primary care roles, including developing a community of practice for GPs with an interest in developing into extended roles. The Service should work with NWL ICS to develop minimum competencies for development of a network of GPs with extended roles in MSK fields across NWL. The Service should also provide education and training for GPs to deliver routine clinically-guided MSK corticosteroid injections in primary care.  Primary care-based health and wellbeing coaches and link workers (including social prescribers) should also be provided with exposure and development within the Service for upskilling and ongoing support. **3.3.4 Triage and Response Times** Patients can be referred to the Service either via self-referral, referral from the GP, or other agreed professionals, such as hospital consultants, A&E / out-of-hours staff, 111 and ambulance services. Referrals should be accepted electronically. There should be a Single Point of Access for all MSK services (including Physiotherapy, Orthopaedic, Rheumatology and Pain services)  All ‘urgent/priority’ and Tier 2 speciality referrals should undergo initial ‘paper’ clinical triage within 3 working days of receipt. Triage can also be undertaken through digital tools, provided there is quality assurance around their accuracy. Routine Tier 1 referrals may undergo triage through digital tools, again with quality assurance around diagnostic accuracy.  Appointment confirmation should be provided to the patient via their preferred method of communication (email, letter, telephone or text). Due consideration should be given to patient requests in view of location day and time, within the practical constraints of the contracted service.  Urgent/Priority, but non-emergency conditions, may sometimes be appropriate for urgent review within the community MSK Service, depending on specific locally agreed clinical pathways and timely review within the Service with appropriate integrated secondary care input (i.e. CRPS, severe post-surgical pain, moderate to severe painful peripheral neuropathy) with timely access to diagnostics. ‘Priority’ criteria will be subject to ongoing review, with a basic outline included in the [Improvement framework to reduce community musculoskeletal waits while delivering best outcomes and experience](https://www.england.nhs.uk/long-read/an-improvement-framework-to-reduce-community-musculoskeletal-waits-while-delivering-best-outcomes-and-experience/) from NHS England.  ‘Priority’ and ‘routine’ waiting times will be subject to ongoing review, depending on demand and resource (including cost) factors.  Patients triaged as ‘priority’ should be contacted by phone and offered an appointment to be seen within 14 calendar days of the date of contact, whilst routine patients should be offered an appointment within 28 calendar days.  If patients are identified as clinical emergencies should be immediately onward referred in line with local or national guidelines.  [Urgent and Emergency Musculoskeletal Conditions Requiring Onward Referral as of December 2020](http://arma.uk.net/wp-content/uploads/2021/01/Urgent-emergency-MSK-conditions-requiring-onward-referral-2.pdf)  Clinical emergencies may include:   * Suspected cauda equina syndrome * Metastastic spinal cord compression * Spinal infection * Septic arthritis * Giant cell arteritis * Unstable acute fractures   If a 2-week-wait (suspected cancer) referral is required, the provider should have a seamless pathway in place to initiate this referral directly.  The Service will provide an appropriate balance of virtual and face-to-face clinical assessments, but where a patient prefers a face-to-face assessment, this should be offered. Distribution of resource between virtual and face-to-face capacity should be continually evaluated, including patient outcome and experience measures.  Inappropriate or incomplete referrals should be returned to the referring clinician within 5 working days, with a clear explanation as to why the referral is being returned.  Outcomes from triage may include:   * Offering an appointment within a specific pathway within the MSK Service (with or without pre-appointment diagnostics) * Offering direct referral onward to secondary care services * Signposting to alternate services * Returning the referral with advice and guidance provided to the referring clinician, to enable ongoing management of the patient within primary care.   Patients may also be sent education and self-management information (which may also be through digital platforms), as appropriate, at initial triage. **3.3.5 Self-referral** The option for patients to self-refer to the Service should be available. This could be via telephone, online questionnaire or other digital applications but must provide equity of access. All incoming referrals will require an appropriate level of triage. **3.3.6 Digital**  The Service will provide digital options which may support patients with initial referral, triage, signposting, along with education and self-management education (i.e. group based sessions). Ideally, digital options should also enable patient control over appointment-booking. Digital patient care should undergo robust and continual evaluation to ensure diagnostic accuracy, quality of care and equality of access.  A digital pathway should be regularly reviewed, with established data benchmarking and KPIs. Sensitivity and specificity of digital screening tools should be scrutinised to ensure safe clinical assessment, without undue escalation of patients to both primary and specialist Tier 2 clinics, or urgent care services.  The digital self-management tools should also be available to primary care clinicians to enable patients to be managed without referral. **3.3.7 Premises** The provider is expected to review and tailor premises as appropriate for patient need, which may change over the length of the contract. Appropriate and flexible access should be made available.  The provider will operate the Service between 0900 and 1700 Monday to Friday, excluding bank holidays. The provider should work to develop evening and weekend service provision, based on demand analysis, within the contract value.  The provider is expected to review and tailor the location of premises to the geographical areas of greatest patient need throughout the contract. Needs may change over the time of the contract and the development of any future locations must be agreed with Commissioners prior to implementation. **3.3.8 Underserved groups** North West London represents a large sector with varying population needs, which includes several under-served groups (such as social support groups of same languages with health coaches/ social prescribers having the interpreters to increase inclusion). The Service should seek appropriate representation with patient partners / lived experienced partners from such communities. Social prescribers may be useful to engage with under-served communities, and appropriate language support will be essential.  Appropriate interpretation and translation services and tools should be employed to meet varying language needs. **3.3.9 Information Management and Technology**  Digital integration and interoperability enables joined up patient care. The Service provider will be required to use an appropriate electronic health record system integrated with primary care to deliver the Service. The Service should use the same digital health record system as predominantly utilised by primary care within that borough (TPP SystmOne and EMIS Web are used by practices in NWL).  The Service should also have appropriate access to the NWL electronic diagnostic ordering system (CliniSys ICE) to order both pathology and radiology diagnostics, as well as viewing of textual results.  The Service should have access to the NWL SOLITON platform and the associated PACS system to enable the service to obtain real-time access to radiology image archiving systems across NWL providers. This is to ensure clinicians are able to view radiology images as well as written reports.  REGO Vantage is the preferred platform for Advice & Guidance across the sector, which the provider should also have access to.  The Provider will be responsible for the provision, maintenance and cost of all Information Management & Technology (IM&T) hardware and software, licenses and IT support services required to meet the needs of the Service. These will need to meet local and national standards and support NHS NWL ICB’s direction of travel regarding interoperability.  The Provider must ensure that appropriate “IM&T Systems” are in place to support the Service before Service Commencement. “IM&T Systems” means all computer hardware, software, networking, training, support and maintenance necessary to support and ensure effective delivery of the Services, management of patient care, contract management and of the organisation’s business processes, which must include:   * Clinical services including ordering and receipt of pathology, radiology and other diagnostic procedure results and reports. * Prescribing. * Choose and Book / eRS (or any future replacement * A single electronic patient health record for every patient, which is identifiable by a unique number (e.g. patient NHS Number). * Inter-communication or integration between clinical and administrative systems for use of patient * demographics. * Systems for referral management and booking for both GP referrals to the Service and onward referral from the Service to a specialist.  **3.3.10 Specialist Advice & Guidance** Specialist advice should be available to support practitioners in both primary and community services. This may occur before a referral is made, or where a referral is made a specialist may review the clinical information and return the referral to the appropriate clinician with guidance or signposting advice to an alternative appropriate pathway.  Specialist advice may be provided by both consultant and non-consultant practitioners in both primary, community and secondary care providers The establishment of regular virtual clinics may assist this.  Primary care GPs or FCPs should be able to seek advice and guidance through the community MSK single point of access, in both a pre- or post-referral manner. Where such expertise is not available within the community service, or where community practitioners require further support for patients within the service, there should be clear and timely access to specialist advice from secondary care.  Within North West London, the agreed digital platform for advice and guidance is the REGO platform, which interfaces with the NHS e-Referral Service (e-RS). The community provider would be expected to utilise this REGO platform to provide support to primary care.  [BestMSK Specialist MSK Advice and Guidance draft guidance](https://future.nhs.uk/NationalMSKHealth/view?objectId=125052997) **3.3.11 Shared Decision Making** With any diagnostic, intervention or management plans, patients should have a discussion, being provided with their options, benefits and risks, taking into account their individual personal preferences and values.  Information should be offered in a variety of formats, including verbal or printed information, or signposting to appropriate online information, in order for patients to make an informed decision about their care.  Appropriate tools may include the [NHS England decision support tools](https://www.england.nhs.uk/personalisedcare/shared-decision-making/decision-support-tools/), or any other tools in accordance with the [NICE framework for shared decision making support tools](https://www.nice.org.uk/corporate/ecd8). For back pain and shoulder pain: <https://www.versusarthritis.org/about-arthritis/healthcare-professionals/musculoskeletal-decision-support-tools/>  Shared decision making should offer options from clinical best practice and national standards, for example those of the NHSE Evidence Based Intervention policies and local PPwT criteria. **3.3.12 Personalised Care** Personalised care will be a key feature for managing long-term conditions. All long-term MSK conditions should be viewed with a whole-person approach, considering individual needs, preferences and abilities. It is important for practitioners and patients to recognise that a ‘cure’ for many conditions will not be available and many treatments only serve as an adjunct to care. A personalised approach should focus on supporting people to identify their own goals and strengths and to improve daily function and quality of life.  Personalised care will largely be continued to delivered within primary care and therefore the Service should work collaboratively (with digital integration) with PCNs and ensure care plans are co-designed and accessible across settings of care and that there is appropriate close working with both GPs and other staff in ARRS roles within PCNs (eg health coaches).  The Service should support a shift away from a purely biomedical model, to incorporate wider principles of chronic condition management, including therapeutic alliance (and continuity), education, exercise and lifestyle and emotional wellbeing, in order build individual self-efficacy. Lifestyle factors may include sleep hygiene, smoking cessation, stress management or vocational support.  All patients with ongoing conditions should be reviewed from a psycho-social perspective to identify non-biomedical areas for support.  The [Making Every Contact Count (MECC)](https://www.gov.uk/government/publications/making-every-contact-count-mecc-practical-resources) approach may be one model of care to empower patients to review and change behaviour, deliverable across practitioners in a community MSK service. Practitioners should be trained to deliver both very brief and brief interventions which may enable and empower patients by signposting them to appropriate support for positive behaviour change.  The Service should work closely with the NWL ICB Personalised Care Workstream initiatives to continually expand this approach throughout both community and primary care settings for patients with long-term MSK conditions.    All patients with long-term health conditions should have a personalised care plan completed jointly in partnership. Once agreed, a copy should be provided to the patient and recorded in the patient’s shared primary care electronic health record.  Information should be available in different languages based on local population needs.  Care plans should include, but not necessarily limited to:   * Patient priorities and their individual goals * List of long-term health conditions and prior treatments and their outcomes * Support services, whether NHS or third-sector, applicable to the patient * Individualised self-management, including advice on management of flares * Access pathways for further support from NHS services   More details:  [NHS Personalise Care Support (PCSP) Checklist](https://www.aomrc.org.uk/wp-content/uploads/2020/12/Personalised_Care_Support_Planning_Checklist.pdf)  [Personalised Care Introductory Pack](https://www.england.nhs.uk/wp-content/uploads/2021/05/care-coordinator-welcome-pack.pdf)  [Guide to completing your personalised well-being plan](https://www.aomrc.org.uk/ebi/wp-content/uploads/2021/05/Personalised_Well-being_Plan_Guidance.pdf)  [Personalised well-being plan template](https://www.aomrc.org.uk/ebi/wp-content/uploads/2021/05/Personalised_Wellbeing_Plan.pdf) **3.3.13 Primary Care & First Contact Practitioners** By providing early MSK point of contact assessment, specialist advice, early guidance and treatment, first contact practitioners (FCPs) may reduce downstream service utilisation, as well as to support to primary care demand.  Whilst NWL ICB cannot mandate primary care networks to recruit from the community MSK provider, the NWL preferred position would be for FCPs to be formally integrated within the community MSK Service, both to enable continuing development and supervision for practitioners, as well as to allow the Service to maintain clinical standards and provide governance for these roles. Ideally FCPs should regularly rotate through both primary care, as well as community clinical settings.  Integration with community services would also enable appropriately qualified FCPs based within primary care to have access to more advanced radiology requests, which would not be routinely accessed in primary care in NWL. If MSK-service based FCPs order more advanced imaging within a primary care setting, interpretation of such results should be undertaken only by that FCP, or within the community MSK service and not by other primary care staff.  This will require close engagement and working relationships between the MSK community Service and neighbourhood based primary care networks (PCNs) across North West London.  First contact practitioners must meet the minimum standards of the [HEE Roadmap to Practice](https://www.hee.nhs.uk/sites/default/files/documents/MSK%20July21-FILLABLE%20Final%20Aug%202021_2.pdf), as well as CQC requirements ([FCP Care Quality Commission myth buster](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-106-primary-care-first-contact-practitioners-fcps))  The provider must work with PCNs to set up IT interoperability for booking and FCP health record and diagnostic access. **3.3.14 Tier 1 Physiotherapist-Lead Services** Tier 1 services should be clinically and digitally integrated with Tier 2 speciality clinics to ensure a seamless bi-directional patient journey and also to enable clinical supervision, with escalation and onward referral of only appropriate cases from Tier 1 to Tier 2, with feedback and upskilling for Tier 1 clinicians.  The service should deliver care using a mix of one-to-one, group, face to face and remote telephone and virtual sessions. Patients should be supported to engaged in both supervised and unsupervised physical activity, tailored to their individual needs, preferences and abilities.  Digital tools should be used to support appropriate patients to self-manage their condition, with education and physical activity advice, for example online ‘Joint Schools’.  There should be provision of adequate capacity of supervised rehabilitation classes for common musculoskeletal conditions, such as osteoarthritis, both virtually and in-person.  Where patients have a preference for face-to-face rather than virtual input, this should be offered.  Appropriate diagnostic labelling should be used in all patient encounters with practitioners.  Basic orthotics should be available within the Service for common MSK podiatric needs (dependent on contract value). NWL does not routinely commission the use of more advanced orthoses.  Manual therapy may be provided, as an adjunct to other evidence-based treatments.  Where necessary, vocational / employment support services should be partnered with in order to plan and facilitate optimum return to work for patients.  The provider should work with existing community-based assets, such as local authority resources, leisure centres, community exercise classes and gyms, to incorporate them into clinical pathways.  Whilst sports and exercise therapists and fitness instructors play a crucial role in the treatment of patients, where a physiotherapy assessment is being commissioned, this should be provided by appropriately qualified physiotherapists or osteopaths.  Hydrotherapy, whilst nice to have, is likely unfeasible to deliver at scale across NWL. Instead, the Service should work with existing NHS, third-sector and private facilities to signpost patients to appropriate aqua-based activities, varying by region and incorporate such locally based assets in clinical pathways (for example Good Boost). **3.3.15 Tier 2 Sub-speciality Requirements:****3.3.15.1 Orthopaedics** Patients with osteoarthritis should be offered a range of management options as per the [BestMSK Osteoarthritis Pathway](https://future.nhs.uk/NationalMSKHealth/view?objectId=108045381), with education and self-management education, non-pharmacological management (including supervised, unsupervised and group exercise), pharmacological management and injections, and appropriate onward referral for surgical candidates.  Patients referred for further surgical procedures should align to best evidence, including the [NHS Evidence Based Interventions](https://www.aomrc.org.uk/ebi/resource/) recommendations.  When onward referred to surgical specialities, detailed shared decision making should be undertaken in the community Service for the patient to understand their options, likely benefits and risks and be at a clearly informed state with regards to preferences when reaching secondary care.  The appropriate diagnostics that would be required for decision-making in a secondary care setting should be organised prior to the patient reaching orthopaedic outpatients.  A public consultation is currently underway in North West London ICB for the development of an Elective Orthopaedic Centre (EoC) to improve quality and efficiency for specific elective surgical pathways.   * The community MSK Service provider would be expected to work collaboratively with such orthopaedic pathways in NWL, to ensure elements of the patient journey, for example shared-decision making around treatment, physiotherapist-lead therapy, both pre-operatively and post-operatively, as well as the collection of key PROMS, may be offered through the community Service, where appropriate. * Partnership working and clinical integration with secondary-care based clinical teams will ensure delivery of a robust clinical pathway, as well as workforce development. * Ongoing alignment with ICS partners will need to take place during the duration of the contract to enable and continually develop this pathway.    **3.3.15.2 Rheumatology**  The Service should aim to support demand on secondary care rheumatology services; ensuring patients with inflammatory disease are expediently seen within such specialist services, whilst managing non-inflammatory conditions (such as fibromyalgia) in primary and community settings (in line with GIRFT recommendations).  The Service should ensure there is appropriate screening and clinician expertise in other service lines (for example Tier 1 physical therapists) to identify patients with potential autoimmune inflammatory or connective tissue disorders that should be onward referred to Tier 2 rheumatological assessment, in order to address the typically delayed diagnosis for many such conditions.  Onward referrals to secondary care rheumatology may be monitored through the proposed benchmark of proportion of patients commenced on secondary care-based treatment (ie DMARD/biologics or secondary-care based osteoporosis treatment).  Same-day point-of-care ultrasound plays an essential role in the efficiency of any rheumatology assessment services and an adequate number of trained practitioners delivering this will be essential for effective service delivery.  The Service will require timely access to further imaging, such as MRI, with appropriate rheumatology protocols. The Service will also require access to specialist rheumatology radiologist MDT input for case discussion.  Rheumatology consultant time may be utilised in different manners, including asynchronous MDT discussion. However, mass one-stop shop clinics (Consultant ‘Attending’ model where a patient may receive point-of-care diagnostics, senior clinical review and physiotherapy in a single episode) may be preferable in view of the high numbers of patients that can be reviewed per consultant session, in order to support the fragile secondary care rheumatology waiting lists and high demand in NWL, as well as to improve efficiency and convenience of the patient journey.  Integration of rheumatology within a wider MSK Service should enable the large proportion of non-inflammatory musculoskeletal presentations to be treated efficiently (ideally same day) with appropriate physical therapy, injection intervention or pain and initial self-management support. Where appropriate, ongoing self-management support can be facilitated by MSK service engagement with PCN-based health and wellbeing coaches and social prescribing link workers.  Future scope would include providing assessment of bone metabolic health and both primary and secondary prevention of fractures through a community setting. Such a service should incorporate principles of shared decision making. **3.3.15.3 Pain Services** The Service should provide care in line with NICE Clinical Guideline NG193 including:   1. A clear diagnosis where possible for patients with chronic pain, including chronic primary pain diagnoses such as fibromyalgia. 2. De-medicalise treatment plans (where appropriate). 3. Provide shared, individualised, personalised care planning aligned to the patient’s individual values and with a focus on health coaching and access to physical activity and mental health support outside of hospital, predominantly at primary care level. 4. Robust triage and expedient onward referral for appropriate candidates for interventional pain procedures. 5. Support medicine optimisation (particularly drugs associated with dependency) for those who have long-term pain.   This would be achieved through a biopsychosocial assessment by an appropriate interdisciplinary competency-based team of specialist pain clinicians, with regular MDT case discussion  In line with the NICE guideline on primary chronic pain and the RCP guidelines on fibromyalgia, patients with primary widespread pain conditions should be offered treatment and support in primary and community services, with development and support to PCN teams provided by the MSK Service.  In keeping with locally agreed pathways, patients appropriate for interventional treatment should be appropriately identified and referred for such treatment from specialist pain teams.  We do not expect the Service to deliver full pain management programmes in view of mixed evidence rather clinical and cost-effectiveness. Instead the Service should provide brief pain education, including through digital means, with a greater focus on individual personalised care planning, and supporting PCNs to provide ongoing support for this group of patients.  Individual and group based physical and psychological approaches should aim to reduce pain (where possible), pain-related physical disability and emotional distress, improve quality of life, support active self-management and reliance on healthcare resource.  This may be achieved through acceptance and commitment therapy (ACT) and/or cognitive behavioural therapy (CBT) techniques to:   * Enhance acceptance, mindfulness and psychological flexibility * Facilitate learning and pain reconceptualization * Identify and clarify values-based goals * Promote behaviour change and enchanged well-being, including methods based on learning and conditioning processes * Facilitate skills training, physical exercise and exposure * Support patients to remain in or return to education and work * Improve sleep quality, quantity and pattern.   All patients with persistent pain should have a single ongoing care plans, co-developed and accessible by all practitioners, including primary care, which should include details of previous treatments trialled and agreed management approaches for ongoing and flare management.  Patient-initiated follow-up for a period of up to 6 months from initial discharge for all patients with persistent pain may help to provide ongoing support and rationalise utilisation based on need.  Borough-based drop-in peer support groups may provide education, social equity and peer support for chronic pain patients. These could be coordinated by the Service on a rolling basis, with non-medical health coaching / social prescriber / FCP facilitation.  The Service should work in partnership with the North West London personalisation workstreams, particularly in developing a network of primary care-based medical and non-medical practitioners who can provide adequate health coaching for patients with chronic pain, which will be key for assessment and optimisation of the common medical co-morbidity faced by patients with chronic pain. Ad-hoc virtual MDT support to primary care for case discussion will enable upskilling.  The Service may work with health coaches employed in ARRS roles by primary care networks, but we would also expect health coaching and social prescribing to be directly available within the Service in view of neighbourhoods where no such support may be available within primary care.  Direct employment of health psychologists within the Service can be challenging. An alternative could be employment of health coaches or social prescribers, along with partnership working with other community psychology services which will be key to enabling certain patients to receive the psychological support required. As highlighted in workforce development, we would expect a large proportion of the practitioner workforce to be trained in psychology-informed practice, with some practitioners holding more advanced psychological training. As per NICE Guideline on Chronic Pain NG193, psychological approaches such as acceptance commitment therapy (ACT) or cognitive behavioural therapy (CBT) can be considered for appropriate patients interested in engaging in such approaches. Links should be established with specialist pain psychologists for support, training and development.  Appropriate medical input will be useful, for example, GPs with extended roles, in order to address relevant medical co-morbidity often present alongside long-term pain presentations.  In view of pressures in secondary care services, rotation of clinical staff through secondary care departments will enable integrated working and professional development. For example, advanced practitioners could support pain consultants in outpatient post-procedure follow up, to alleviate waiting time pressures (Whilst mindful of practitioner time).  Additional indicators may be useful for patients with persistent pain, such as QoL questions, PSEQ (pain self -efficacy questionnaire), activation measures, health confidence scores, etc. For example, positive clinical outcomes could include: pain intensity; disability/physical activity; emotional wellbeing; health related quality of life; productivity; medication and health care utilisation. Such indicators will be made available in the patient’s shared record and care plan.    Future scope of the pathway may include expanding pain self-management care to patients with non-pain chronic fatigue syndrome as this has been identified as a current unmet need across most boroughs in NWL, involving largely overlapping principles of health coaching.  Appropriate candidates for interventional procedures should be accurately identified (an acute radicular pathway; seen Spinal section below) with an expedient pathway for these patients to receive intervention in secondary care services in a timely manner. **3.3.15.4 Spinal & Radicular Pain** A spinal and radicular pathway should be in place, in keeping with national and locally agreed guidelines and policies. Such pathway should be adopted by all practitioners across the Service.  Engagement with local neurosurgical teams and pain specialists will be key, ideally with rotation of staff through local secondary care spinal MDTs to improve delivery of both surgical and non-surgical management.  The Service should offer an appropriate acute pathway to manage patients in accordance with locally agreed criteria and NICE NG59, with appropriate assessment, imaging and intervention (where appropriate) in a timely and cost-effective manner for patients with new onset severe radicular pain. This requires highly trained appropriate clinical triage to identify the very small percentage of patients with sciatica who would be candidates for epidural injection. It will also require direct-listing ability with either radiology or pain services in secondary care.  Future scope of the Service could include routine ultrasound-guided caudal epidural provision delivered by advanced practitioners within the community, for appropriate patients and with suitable clinical oversight. **3.3.16 Medicines Optimisation****3.3.16.1 Medication Reviews and De-prescribing** The Service should support appropriate prescribing. This is particularly important in the context of patients with long-term MSK conditions. Opportunities for appropriate de-prescribing of low-value (i.e. ineffective, cost-ineffective, or harmful) pharmacological management should regularly be undertaken. This is particularly important in the context of opioid, gabapentinoids, sedatives, as well as cost-ineffective treatments such as lidocaine patches which may be commonly over-used in this patient population.  Specialist prescriber or pharmacist input within the Service will be useful to provide appropriate medication reviews, in line with [NICE guideline NG215 Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults](https://www.nice.org.uk/guidance/ng215). Shared decision processes should be employed at all stages of such prescribing or de-prescribing.  The Service should support PCN based pharmacists in identifying and supporting patients on low-value dependency-forming medications, to de-prescribe and provide alternative holistic support. This may be achieved through drop-in virtual MDT support (from a combination of specialist pharmacist, nurse or pain consultant input), following standardised titration protocols. **3.3.16.2 Prescribing** When issuing prescriptions or recommendations, the Provider should use the appropriate locally agreed formulary. GPs should not be asked to prescribe non-formulary products.  Prescribers should follow local prescribing guidelines and approved shared care agreements.  The provider should be enabled on the NHS Digital Electronic Prescription Service (EPS) in order to send prescriptions electronically to a dispenser of the patient’s choice, increasing efficiency and convenience for patients and staff. The provider should work with the appropriate North West London Medicines Management Team to incorporate appropriate governance for prescribers, including audit and monitoring as well as prescribing budget management.  For non-urgent prescriptions, or those that can start after 14-days, a letter should be sent to the GP within 7 days, with fully details of the medicine to be prescribed. For treatment to be started within 14 days, a 28-day supply of medication (or complete course, if shorter) should be issued (via EPS) and a letter sent to the patient’s GP with details of the prescribed medicine.  The Provider should demonstrate compliance with any relevant recommendations in local and national safety alerts, noticed and good practice guidance. **3.3.17 Diagnostics** Shared decision-making should again be used prior to any diagnostics, outlining the possible benefits, as well as potential risks (for example incidental findings, or increased worry and over-medicalisation due to imaging findings).  There should be an emphasis on appropriate guideline and evidence-based use of imaging within the Service, to ensure patients receive the most appropriate diagnostic test and to avoid unnecessary low-value diagnostic requesting.  Whilst specific MSK imaging guidelines will be co-developed locally, broadly radiological imaging should be discouraged unless 1) Serious pathology is suspected 2) There has been an unsatisfactory response to conservative care or unexplained progression of signs and symptoms 3) It is likely to change management ([What does best practice care for musculoskeletal pain look like? Eleven consistent recommendations from high-quality clinical practice guidelines: systematic review, British Journal of Sports Medicine 2020](https://bjsm.bmj.com/content/54/2/79#boxed-text-4)).  Locally agreed clinical pathways should be adhered to, guiding the appropriate tests in each setting of care. For example, only plain radiology, DEXA bone density scanning and locally agreed blood work would be routinely expected in primary care for MSK patients.  The Service should have direct access to several relevant diagnostics including, but not limited to:   * Pathology Testing, particularly for suspected inflammatory rheumatology cases * Plain Radiographs * Musculoskeletal ultrasound * Musculoskeletal MRI (with appropriate reporting protocols for inflammatory conditions) * Bone Density (DEXA) scanning * Neurophysiology (Nerve Conduction / EMG studies)   Arrangements should be in place for the Service to access diagnostics urgently (e.g. within two weeks), where necessary for certain clinical pathways and locally agreed guidelines.  Routine diagnostics should be completed, reported and documented in line with national and locally agreed guidelines.  The North West London Radiology Board has moved in recent years to remove routine direct access musculoskeletal ultrasound and MRI access from primary care. This was based on evidence of inappropriate/un-indicated utilisation, as well as, more importantly, misinterpretation of results leading to patient harm, as well as resource implications on radiology services. There is little evidence to support improved clinical outcomes through the use of advanced musculoskeletal diagnostics in primary care. Within NWL, such imaging is shifted along the pathway to be undertaken in the more specialist settings of the community MSK interface service. This increases the pressure on the MSK Service to take ownership of a larger proportion of MSK imaging across the NWL population, to ensure appropriate diagnostic utilisation and interpretation. **3.3.17.1 Point of Care Ultrasound** There is an evolving role for point-of-care ultrasound (POCUS) performed by appropriately qualified and supervised clinical practitioners, whilst not radiologists, to enhance the care pathway. This can be by providing faster patient journeys with fewer episodes of care through the delivery of ‘one-stop shop’ clinics, improving diagnostic accuracy, providing additional functionality for image-guidance of more advanced procedures, and a key enabler for rheumatology assessment services.  POCUS capacity within the MSK Service is even more crucial in view of the removal of advanced MSK imaging from primary care in NWL, placing a greater burden on imaging within the interface element of the pathway. Staff should be appropriately qualified (or in supervised training), meeting a minimum standard of UK CASE accredited training, with ongoing mentorship and development. Appropriate supervision and co-reporting should be in place where trainees are scanning.  A sufficient number of advanced practitioner staff should have appropriate training to deliver POCUS in order to meet demand and reduce pressures on departmental radiology services and reduce the patient journey.  POCUS activity will not be unbundled, separately billed radiology activity, but reflected in tariffs for specialist clinics, encouraging clinicians to judiciously deploy this resource.  Relevant policies include the [CSP Professional Guidance on Point of Care Ultrasound](https://www.csp.org.uk/professional-clinical/professional-guidance/point-care-ultrasound-physiotherapy-practice) and the [Faculty of Sports and Exercise Medicine MSK Ultrasound Guidelines (jointly with the BSSR).](https://www.fsem.ac.uk/wp-content/uploads/2019/08/FSEM-UK-MSK-US-Guidelines-May-2019.pdf)  The Service will be expected to have direct access to relevant digital diagnostic requesting and result reviewing platforms utilised across NWL (including ICE for pathology and SOLITON along with the associated PACS system for imaging, as well as GP electronic health record, to enable access of patients’ diagnostic history undertaken in other settings of care. Relevant clinicians within the Service should have the ability to view radiology images (undertaken by NWL radiology providers) in addition to textual reports.  IT inter-operability should be in place to allow diagnostic sharing. This may be via IEP, or through direct access to the PACS system for real-time immediate image viewing of radiology undertaken within the NWL radiology network. The implementation of Soliton Plus across the NWL diagnostic providers should enable such live two-way image review of diagnostic scans undertaken within these providers. IT inter-operability should seamlessly allow patient diagnostic results to be carried through with them to any onward referral settings of care (again, via the NWL SOLITON platform where possible), in order to prevent delays in patient journey or duplication of diagnostics.  Arrangements should be in place (for example through MDT working and service level agreements) for specialist MSK radiology input for complex cases, for example, inflammatory rheumatological diagnoses.  Regular benchmarking and audit should be undertaken at organisational and individual practitioner level for imaging requesting and interpretation, alongside relevant training, to ensure appropriate utilisation of diagnostic resources.  In view of the large burden of normal age and/or activity related changes seen on MSK imaging, practitioners should all be trained in the appropriate interpretation of imaging findings, their relevance to clinical symptoms, and translation of these results to patients). Where possible, all practitioners should be trained in the appropriate use of effective language, whilst avoiding the use of nocebic terminology when describing imaging findings to patients.  Clear processes must be in place for unexpected/incidental diagnostic findings. **3.3.18 Procedures** The Service should have the capability and capacity to provide a range of procedures without requiring onward referral to secondary care services.  With all procedures, practitioners should judiciously utilise resources, with appropriate patient selection and adherence to national and locally agreed evidence-based guidelines.  Shared decision-making, explaining the likelihood of benefit and risks should be discussed prior to all interventions. **3.3.18.1 Injections** Whilst many injection therapies provide only limited or short-term benefit, they play a crucial role in management for some patients. Evidence for improved outcomes and/or safety for ultrasound-guided versus landmark-guided injections is limited. Nonetheless, some procedures may be more accurately and safely delivered through ultrasound guidance, for example, injections of the foot, or deeper injections such as the hip joint.  The Service should be able to provide corticosteroid injections for the following targets, performed by appropriately trained staff:   * AC joint * Subacromial space and glenohumeral joint * Carpal tunnel * De Quervain Tenosynovitis * CMC and other small joints in hands * Stenosing tenosynovitis * Hip joint * Knee joint * Foot and ankle joints   \* Whilst some targets may require image guidance, many can be delivered by clinical landmark guidance and practitioners should use judgement with regards to time and equipment resource, as well as the current evidence-base, when deciding on image-guidance.  The Service should support the upskilling of primary care to deliver corticosteroids injections appropriate for this setting. Unmet need for corticosteroid injections within primary care may also be supported through First Contact Practitioner roles.  The Service should be able to provide more advanced procedures, many of which require ultrasound guidance, to reduce pressures on secondary care specialist / radiology services and to reduce the patient journey. These may include, but not be limited to:   * Ultrasound-guided calcific tendon barbotage * Ultrasound-guided suprascapular nerve block * Ultrasound-guided shoulder hydrodistension   As above, future scope of the service could include ultrasound-guided caudal epidural provision delivered by advanced practitioners within the community, for appropriate patients and with suitable clinical oversight.  Injections of other substances, including hyaluronic acid or platelet-rich plasma (PRP) would not be expected within the community service.  Transcutaneous electrical nerve stimulation (TENS) therapy would not be expected within the Service. **3.3.18.2 ESWT** Whilst evidence and guidelines may be evolving, extracorporeal shockwave therapy (ESWT) would be desirable within the community services for persistent tendon problems, for appropriate cases such as foot and ankle which have not responded to first-line treatment. **3.3.18.3 Acupuncture** In line with [NICE Guideline on Chronic Pain NG193](https://www.nice.org.uk/guidance/ng193/chapter/Recommendations), there may be an appropriate role for acupuncture for patients with chronic primary pain, which could be considered within the Service, up to no more than 4 hours of healthcare professional time or delivered by another healthcare professional with appropriate training for equivalent or lower cost.  Delivery of such provision would be left to the discretion of the Service, pending resource implications within the scale of the contract. **3.3.19 Onward Referrals** Direct referrals can be made from the Service to hospital care for MSK related conditions. This should be undertaken via the appropriate digital platform (i.e. eRS).  Where onward referral to hospital-based care is required (e.g., for surgery or adolescent patients that require paediatric specialist opinion), the Service will be required to provide:   * Informed choice of provider for patients – patients must be presented with information on options they have for choice of provider when referred to hospital. * Notification to the patient’s GP within 7 days. * Direct listing to an interventional procedure where appropriate and where arrangements are in place (typically, supported by Service Level Agreements with local secondary care providers) and patient choice is offered. * All diagnostics results and patient notes under agreed information sharing arrangements with hospital providers to prevent diagnostics duplication and * Processes and pathways for rapid onward referral of patients with suspected malignancy, under 2 week wait rules, ensuring follow up with the receiving provider to ensure the referral has been received and actioned. * Processes and pathways for rapid onward referral of patients with suspected early inflammatory arthritis where NICE requires treatment within 6 weeks of GP referral, ensuring follow up with the receiving provider to ensure the referral has been received and actioned. Data should be added to the EIA audit * The Service must have in place pathways and processes for urgent referral to A&E for emergencies.   Mechanisms should be in place to allow tracking of onward referrals in order to seamlessly follow up appropriate benchmarking data (for example conversion rate to secondary care interventional procedures, or patients started on disease-modifying medication).    **3.3.20 Discharge**  All patients at discharge from the Service should have a clear documented suspected diagnosis (with clear reasoning for that diagnosis) along with documented treatment options and plan.  This should be copied to the patient as well as to the GP practice within a timely manner, within 5 working days.  **3.3.21 Data set and outcome measures**  The Provider should work closely with the ICB to analyse system data and assess all areas of the pathway for clinical and cost-effectiveness and patient experience.  A proposed minimum standard dataset for all patients may include the [Keele Community Services Standardised Dataset](https://www.keele.ac.uk/media/k-web/k-schools/pcsc/researchmicrosites/msk-community-services-standardised-dataset-supporting-document.pdf), as well as the appropriate NHSE benchmarking dataset ([Community Services Data Set from NHS Digital](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/community-services-data-set)).  The preferred patient outcome measure for NWL MSK will be the MSK-HQ questionnaire. The Service should use a range of tools, including automated digital platforms, to capture baseline pre-appointment and outcome MSK-HQ scores for as many patients as possible moving through the service.  Through FCP roles, capture of MSK-HQ data for patients in primary care will be useful. Benchmarking of referral activity from primary care will help identify areas for additional support to address variation in primary care activity.  Additional relevant metrics included those suggested from NHS England’s London MSK Board include:   * Bypass rates (secondary care referrals bypassing the community service) * Waiting times (for both community and secondary care services) * Proportion of patients referred to orthopaedics and pain services who undergo an interventional/surgical procedure (‘surgical conversion rate’) * Proportion of patients referred to rheumatology started on cDMARD or bDMARD treatment (proxy measure of referrals for inflammatory conditions) or secondary care based osteoporosis treatment * Proportion of patients in secondary care pain receiving NHS Evidence-Based Interventions * Prescribing rates of opioids and gabapentinoids * Utilisation of digital decision aids to support shared decision-making * Healthcare utilisation: GP visits, A&E visits, Scans in last 3 months.   The Provider will submit data on (i) waiting times (broken down by geography, condition, deprivation, ethnicity, etc) and on (ii) Non-attendance (DNA) rates (broken down by geography, condition, deprivation, ethnicity, etc) and other health inequalities data as required.  The Service should also routinely (e.g. monthly) report on:-  - waiting times by geography and condition, with attention to deprivation, ethnicity  - Nonattendance (DNA) rates, with attention to geography, deprivation, ethnicity  The Service will be expected to work with NWL ICS and data analyst teams to provide continual ongoing evaluation to demonstrate value in all areas of service delivery, providing insights on population health outcomes (paying attention to inequalities, for example through the Core20PLUS5 framework) and health system utilisation.  Appropriate borough-based and individual clinician level (with appropriate case-mix adjustment) benchmarking should be available against agreed KPIs and other measures to identify areas of variation for quality improvement within the service. **3.3.22 Patient Engagement and Experience** The Provider of the community musculoskeletal service will be expected to involve patients, carers and the public in the planning and monitoring of the service, including any future developments throughout the contract term.  Patient satisfaction with the service will be monitored as a KPI with the expectation of the highest possible satisfaction and at least 75% of patients will report a positive experience of the service.  Appropriate patient reported experience scores (PREMS) should also be captured, in line with national guidance on appropriate validated and patient-orientated questionnaires. **3.3.22.1 Complaints** The Provider will be expected to act upon patient feedback in all its forms including the provision of a clear complaints procedure and make adjustments as appropriate to ensure they continue to deliver a high quality patient centred service. It is the Provider’s responsibility to ensure that a variety of mechanisms exist, are supported, and resourced to enable patients to give feedback on the Service and also to report back on actions taken and how the Service is improved as a result.  The Provider shall:   * Have a formal complaints policy and procedures through which patients can raise issues with the Service. * Endeavour to resolve any complaints directly with patients, and only escalate to the Commissioner if the complaint cannot be resolved directly. * Adhere to local Commissioner policies and procedures regarding complaints, including the need to inform the Commissioner of all complaints. * Demonstrate appropriate learning and actions from feedback and complaints to improve future service delivery.  **3.3.23 Evidence-Based Practice, Teaching, Audit and Research**  In view of the recognised gap between evidence and clinical practice within musculoskeletal care, the Service will be expected to undertake continual review of all practitioner activity, along with appropriate mentorship and provision of training opportunities.  The Provider should undertake a range of audit, evaluation and research, particularly in view of the level of regional health utilisation data available. This could be undertaken as formal research, with appropriate ethics oversight, or informal service evaluation. Engagement with the NWL MSK board and NWL MSK network would identify areas of impactful study and key questions to explore through available data. Partnership working with academic institutes would be encouraged to robustly analyse data and particularly to evaluate any service innovations for both clinical and cost-effectiveness.  Ideally the Service should identify a formal research lead within the Service, with academic experience, to oversee such work.  **APPENDIX A: National Guidelines, Policies, Tools**   * [An improvement framework to reduce community musculoskeletal waits while delivering best outcomes and experience](https://www.england.nhs.uk/long-read/an-improvement-framework-to-reduce-community-musculoskeletal-waits-while-delivering-best-outcomes-and-experience/) from NHS England includes recent co-design principles for effective service delivery. * [NHS Accessible information standard](https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/) * [Support for carers](https://www.nhs.uk/conditions/social-care-and-support-guide/support-and-benefits-for-carers/) * Related National guidelines, which would be considered along with local effectiveness and health needs assessment review, include:   + [North West London CCG Clinical Guidelines](https://www.nwlondonccg.nhs.uk/professionals/referral-guidelines-and-clinical-documents) include information on previously agreed pathways, including local MSK and diagnostic guidelines. These published pathways are under review and due for updating.   + Previous [North West London PPwT Policies](https://www.nwlondonccg.nhs.uk/services/your-health/planned-procedures-with-a-threshold).   + [NHS Evidence-based interventions programme](https://www.england.nhs.uk/evidence-based-interventions/) provides guidance to improve the quality of care by reducing unnecessary interventions, preventing avoidable harm and optimising use of resources.   + [NICE | Osteoarthritis in over 16s: diagnosis and management [NG226] October 2022](https://www.nice.org.uk/guidance/ng226)   + [NICE | Low back pain and sciatica in over 16s: assessment and management [NG 59] November 2016](https://www.nice.org.uk/guidance/ng59)   + [NICE | Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain [NG193] April 2021](https://www.nice.org.uk/guidance/ng193)   + [NICE | Rheumatoid arthritis in adults: management [NG100] July 2018](https://www.nice.org.uk/guidance/ng100)   + [NICE | Gout: diagnosis and management [NG219] June 2022](https://www.nice.org.uk/guidance/ng219)   + [NICE | Spondyloarthritis in over 16s: diagnosis and management [NG65] February 2017](https://www.nice.org.uk/guidance/ng65)   + [NICE | Osteoporosis: assessing the risk of fragility fracture [CG146] August 2012](https://www.nice.org.uk/guidance/cg146)   + [NICE | Joint replacement (primary): hip, knee and shoulder [NG157] June 2020](https://www.nice.org.uk/guidance/ng157)   + [UKSSB National Back Pain Pathway](https://www.ukssb.com/improving-spinal-care-project)   + [Best MSK Spinal Pathways](https://future.nhs.uk/NationalMSKHealth/view?objectId=27227088)   + [BestMSK / GIRFT National Suspected Cauda Equina Syndrome Pathway (Draft)](https://future.nhs.uk/NationalMSKHealth/view?objectId=144985509)   + [Best MSK toolkit for primary and community care 2022](https://future.nhs.uk/NationalMSKHealth/view?objectId=128041093)   + Relevant policies for point-of-care ultrasound include the [CSP Professional Guidance on Point of Care Ultrasound](https://www.csp.org.uk/professional-clinical/professional-guidance/point-care-ultrasound-physiotherapy-practice) and the [Faculty of Sports and Exercise Medicine MSK Ultrasound Guidelines (jointly with the BSSR).](https://www.fsem.ac.uk/wp-content/uploads/2019/08/FSEM-UK-MSK-US-Guidelines-May-2019.pdf) * The [BestMSK Health Collaborative FutureNHS platform](https://future.nhs.uk/NationalMSKHealth/groupHome) has a range of resources, including a [primary and community care toolkit](https://future.nhs.uk/NationalMSKHealth/view?objectId=33611728) and a [toolkit](https://future.nhs.uk/NationalMSKHealth/view?objectId=29523216) and case studies to develop and integrate FCP services. * The CQC [GP mythbuster 106: Primary care first contact practitioners (FCPs)](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-106-primary-care-first-contact-practitioners-fcps) provides clarity around such novel roles within primary care. * The [Outpatient and Recovery Transformation FutureNHS platform](https://future.nhs.uk/OutpatientTransformation) has specialty resources for [MSK](https://future.nhs.uk/OutpatientTransformation/view?objectId=15214768) across orthopaedics, rheumatology and spinal conditions. This include implementing PIFU and referral optimisation integrating advice and guidance/specialist advice. * The [ARMA](http://arma.uk.net/)(Arthritis and Musculoskeletal Alliance) website signposts the most relevant and useful resources and information specifically about MSK health inequalities, prioritising those which have a UK focus, which draw useful findings or are most likely to help those trying to address health inequalities. * The Personalised Care team has produced [decision support tools](https://www.england.nhs.uk/personalisedcare/shared-decision-making/decision-support-tools/) for [Dupuytren’s contracture](https://www.england.nhs.uk/wp-content/uploads/2022/07/Making-a-decision-about-Dupuytrens-contracture.pdf), [carpal tunnel syndrome](https://www.england.nhs.uk/wp-content/uploads/2022/07/Making-a-decision-about-carpal-tunnel-syndrome.pdf), [hip osteoarthritis](https://www.england.nhs.uk/wp-content/uploads/2022/07/Making-a-decision-about-hip-osteoarthritis.pdf) and [knee osteoarthritis.](https://www.england.nhs.uk/wp-content/uploads/2022/07/Making-a-decision-about-knee-osteoarthritis.pdf) * The [MRI spinal leaflet for clinicians](https://www.england.nhs.uk/publication/mri-spinal-leaflet/#heading-2)is aimed at reducing unwarranted variation in requests for MRI scans for spinal conditions and was developed by spinal clinicians in collaboration with lived experience partners. It supports clinicians when considering whether an MRI scan is appropriate. [A patient leaflet](https://www.england.nhs.uk/publication/mri-spinal-leaflet/#heading-1) is also available. * These charities have resources to help people manage their MSK conditions:   + [Arthritis Action](https://www.arthritisaction.org.uk/)   + [Versus Arthritis](https://www.versusarthritis.org/?gclid=Cj0KCQiAvqGcBhCJARIsAFQ5ke7pfIFt_54ULnhlQXTLkAkzsthGVrrCBxEJhAlz4TtIo7N6vavZvoMaAiTCEALw_wcB). * Tools to support secondary care providers’ contractual requirements: [The interface between primary and secondary care: key messages for NHS clinicians and managers](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Fpublication%2Fthe-interface-between-primary-and-secondary-care-key-messages-for-nhs-clinicians-and-managers%2F&data=05%7C01%7Ckate.jackson9%40nhs.net%7Cb731411d8b4c442700c708dad6d0b433%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638058489099020602%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=4n%2BTwPn%2B%2Fqhxp6q8OMtUv2QgAtcYwbecq8HB4Dtaw7k%3D&reserved=0) and [Standard contract provisions primary and secondary care implementation toolkit](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Fpublication%2Fstandard-contract-provisions-primary-and-secondary-care-implementation-toolkit%2F&data=05%7C01%7Ckate.jackson9%40nhs.net%7Cb731411d8b4c442700c708dad6d0b433%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638058489099020602%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=%2BwbE7%2B7WkD57fxFc3iq1d2mnelcZQIy2QMRSAvyJYUs%3D&reserved=0). |
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