**SERVICE SPECIFICATION**

Hillingdon Integrated Community Musculoskeletal Service

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# Version Control Summary

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| Version | Date | Author | Summary of changes |
| 1.0 | 27 Dec 2017 | Sarah Walker | First Draft – combining existing MSK specs. Removing duplication. |
| 2.0 | 30 Jan 2018 | Claire Waddell | Second Draft - Updated content and KPI’s. Incorporated feedback from Clinical Lead Angela Joseph. |
| 3.0 | 12.02.18 | Claire Waddell | Third Draft - Incorporated further feedback from Clinical Lead Angela Joseph. |
|  | 13/02/2018 | Claire Waddell | Fourth Draft- Incorporated feedback from procurement team (Tom Baker, David Brownlow) |
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# 1 Introduction

This service specification outlines the aims and objectives, pathways, governance, and standards for an Integrated Community Musculoskeletal (MSK) Service.

The proposed service incorporates the existing services currently delivered in Hillingdon, which are MSK CATs, Community Physiotherapy and Rehabilitation, Trauma and Orthopaedic outpatients, Rheumatology and DMARDs outpatients, and Community MSK Chronic Pain services.

The new Integrated MSK pathway will deliver assessment, treatment and management for all MSK-related problems for Hillingdon patients. The integration of these services is intended to reduce the duplication of service provision and improve system efficiency. This will improve the quality of care delivered, and ensure that patients receive the right care at the right time via a seamless, coordinate service.

This specification does not include the Fracture Liaison Service (FLS) or Falls clinics, however they are considered to be closely aligned to the Integrated Community MSK Service and will need to coordinate appropriately. The inclusion of these services may be part of future service development.

# Population needs

## 2.1 Strategic Context

### **2.1.1 National Context**

In July 2006 the Department of Health published the Musculoskeletal Services Framework promoting the redesign of services which draw on the skills and expertise of clinicians to improve outcomes for patient through a more actively managed pathway of care. Some services are delivered as a ‘one-stop-shop- approach providing assessment, diagnosis, treatment or referral to other specialists. This is intended to achieve an avoidance of unnecessary patient attendances and elective admissions.

Demand for musculoskeletal services is high and has increased over the decade, particularly in the last 3 years: nationally, MSK conditions generally comprise around 30 per cent[[1]](#footnote-1) of all primary care consultations.

Musculoskeletal disorders (MSDs) have consistently been the most commonly reported type of work-related illness since records began. In the latest figures recorded in 2013/14 an estimated 526,000people in Great Britain, who had worked in the last year, believed they were suffering from a MSD that was caused or made worse by their current or past work. An estimated 8.3 millionworking days (full day equivalent) were lost through MSDs in GB in 2013/14. Within the NHS, half of sickness absenceis caused by MSDs.

Arthritis Research UK estimates that there are approximately 10 million people living with long term musculoskeletal pain in the UK. Numbers are likely to gradually increase, with improved life expectancy and an increasing number of older people.

The evidence base considered includes:

* The Musculoskeletal Services framework DH 2006
* NICE Guidance [CG177], Osteoarthritis; The Care & Management of Osteoarthritis in Adults. Feb 2014
* NICE Guidance, Rheumatoid Arthritis; The Management of Rheumatoid Arthritis in Adults. Feb 2009
* National Service Frameworks where applicable (Long Term Conditions, Older People)
* Healthcare Commission – Core Standards
* Healthcare Profession Council Standards
* The Chartered Society of Physiotherapy – Core Standards and Service Standards
* Evidence suggests that a service that can provide quick access and effective treatments can improve patient outcomes and avoid patient conditions from becoming chronic [[2]](#footnote-2)

### **2.1.2 Local Context**

Hillingdon Clinical Commissioning Group (CCG) has worked in collaboration with other North West London CCG’s to deliver an ambitious out of hospital programme, which has involved the implementation of the Shaping a Healthier Future programme. This programme has involved significant reconfiguration of services requiring a fundamental change to the way both acute and community services are delivered with a focus on delivering care as close to patients’ homes as is possible.

In Hillingdon there is amixed provision of MSK services comprising of hospital based, community-based and some GP practice based services. The provision of MSK services in Primary Care delivers significant benefits; providing a more convenient service to patients and helping to relieve the pressure on secondary care services, which can then focus on the most complex MSK diagnostics and treatment. The majority of patients would also prefer to access services either within their practice or at a local site closer to their home, rather than an acute hospital site.

In our Commissioning Intentions, Hillingdon signalled that we plan to commission an Integrated Community MSK Service that meets our population’s needs. In the past, MSK services in Hillingdon have been commissioned to address emerging gaps in the system to meet patient’s needs and to improve system sustainability in the context of the CHS’ five Year Forward View. For instance, in April 2016, a Chronic Pain and a Trauma and Orthopaedics (T&O) Treatment and Assessment (MSK CATs) services were introduced to the MSK pathway. Whilst these services enhanced the clinical pathway for patients and enabled some referral demand-management, the overall MSK pathway remained fragmented with multiple entry points, and increased hospital-based procedures. As a result the planned improvements in clinical outcomes, and in financial savings for the system were not realised, contributing to poor financial sustainability, which has undermined system resilience.

Therefore, the intended aim of introducing an Integrated Community MSK Service is to operationally integrate all current MSK services with a single point of access (SPA). It is anticipated that this will reduce the duplication of referrals occurring, and ensure that patients receive a coordinated care plan, which delivers the right care at the right time, avoiding unnecessary secondary care referrals and procedures. In addition, the service will have the capacity to accept and triage all referrals, including those suitable for the suspected cancer ‘two week wait’ pathway.

## 2.2 Outcomes

### **2.2.1 NHS Outcomes Framework Domains & Indicators**

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| **Domain 1** | **Preventing people from dying prematurely**This service contributes towards prevention of premature death through rapid response to urgent MSK related needs, improved self-management, simplified MSK planned care pathways and improved appropriate referrals through a single point of triage. |
| **Domain 2** | **Enhancing quality of life for people with long-term conditions**This service is intended to support the on-going management of patient care in an environment known to them and with professionals they may recognise. People with MSK conditions who need regular treatment will be able to undertake this in a setting close to home. It will negate or reduce the need to spend time in hospital, both for attending outpatient appointments and for recovery from surgical procedures. The service will also ensure a higher proportion of people feel supported and educated to manage their MSK condition. |
| **Domain 3** | **Helping people to recover from episodes of ill-health or following injury**This service is intended to support the management of a patients’ care in an environment known to them and with professionals they recognise. Patients recovering from an MSK related episode of ill-health who need regular treatment or follow up will be able to receive this in a setting close to home. |
| **Domain 4** | **Ensuring people have a positive experience of care**The patient will be at the centre of care with the registered GP providing, managing and coordinating the care received. The CCGs vision is therefore that MSK services are available to patients in a setting as close as possible to the patients home. This addresses the indicator of improving people’s experience of outpatient care. The service is delivered by professionals that the patient recognises and trusts which addresses the indicator of improving people’s experience of integrated care. |
| **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm**The chances of MSK complications developing can be significantly reduced by good MSK care, including attending to risk factors and timely referral and intervention, thus protecting from avoidable harm. In addition, the provider must ensure that all staff delivering the service are competent to do so. The specification sets out the policies that a provider is expected to have in place and ensure that these policies are used within the delivery of the service.The CCGs also require the service provider(s) to use a suitable integrated IT system, such as SystmOne to deliver the service. These address the indicators that patient safety incidents are reported – they are reported on the system that clinicians have access to and that there is a reduction in incidence of avoidable harm – the service is delivered by trained staff with the appropriate policies e.g., infection control in place. |

### **2.2.2 Locally Defined Outcomes**

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| Individual Empowerment and Self Care Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing. There is a focus on care plans for each patient including goals agreed between clinician and patient, as well as increased access to education, particularly for newly diagnosed patients. |
| Access, Convenience and ResponsivenessOut of hospital care operates as a seven day a week service. Community health and care services will be accessible, understandable and effective as well as being tailored to meet local needs. Access arrangements will be face-to-face, telephone, email, SMS texting and video consultation. |
| Care Planning and Multidisciplinary Care Delivery The provider is required to deliver care from community sites (hubs) within a given waiting time, supporting care being delivered as close to a patient’s home as possible. Individuals using community health and care will experience coordinated, seamless and integrated services using evidence based care pathways, case management and personalised Care Planning. Effective Care Planning and preventative care will avoid deterioration of conditions, and most patients will receive their care, including follow up care in the community setting to avoid referral to secondary care. All providers will implement the clear core model MSK management pathway for MSK care. |
| Information and CommunicationWith an individual's consent, their health and social care record will be shared between care Providers. Monitoring will identify any changing needs so that Care Plans can be reviewed and updated by agreement.The provider must ensure that IT systems are interoperable with primary care systems e.g. SystmOne or Emis. Access to GP systems will enable the provider to access, as appropriate the patient’s clinical record to document the appointment, receive the result and document that this has been shared with the patient. Interoperability with SystmOne or Emis also enables the provider to highlight forthcoming appointments, requests for attendance or review.  |
| Population- and prevention-orientedThe provider is expected to deliver early detection and treatment of MSK conditions and support patients from hard to reach groups by providing them with an MSK service in their community, from professionals they know and trust. The provider is required to proactively engage with the patient as appropriate, to support uptake for clinical review and attendance at forthcoming appointments. The Provider has a responsibility to pro-actively support the health and wellness of the local population. This includes prevention (e.g. immunisation, smoking cessation, healthy living), case-finding (e.g. diabetes, COPD, cancer) and pro-active identification and support for patients from hard to reach groups.  |
| Safe and high qualityA single point of referral will be provided to ensure referrals are directed to the most appropriate area of the MSK service in a timely fashion. The provider should have access to the whole patient record so that they can contextualise patient results and advise on next steps. The provider will ensure that patients experience high quality, evidence-based care and clinical decisions are informed by peer support and review. Clinical data are shared to inform quality assurance and improvement. |

### **3 Service Scope**

### **3.1 Service Aims**

The main aim of the Service is to deliver a consultant-led multidisciplinary integrated community-based MSK service (known herein as the ‘Service’). The Service will be provided for the GP-registered Hillingdon adult, and young adult population (16+). The service will provide multidisciplinary assessment, diagnosis, care planning and treatment for people with MSK problems. The specialities that are included within the Service are:

* MSK CATs
* Community physiotherapy and rehabilitation
* Trauma and orthopaedic outpatients
* Rheumatology and DMARDs outpatients
* Community MSK chronic pain management.

### **3.2 Service Objectives**

**3.2.1 Demand Management**

* To provide a high quality patient-centered service to the population of Hillingdon, supporting both inpatient and outpatient activity, reducing unnecessary referrals for secondary care and procedures
* To provide a single point of access, and central booking system for eligible patients for all specialties listed above
* To provide high quality clinical and administrative triage of all referrals to the Service as part of a robust and effective SPA process
* To manage a clear and robust pathway of care such that patients can move seamlessly through the specialties to best meet their needs
* To ensure improved navigation and communication for patients and timely and appropriate onward referral to specialist services where indicated
* To enhance the management of patients within the primary care and community settings to reduce the current reliance on secondary care service provision
* To ensure that the care for patients with long term MSK problems is not placing unnecessary demands on other services, particularly secondary care services
* To ensure that there is no delay to the 2 week cancer referral pathway, or to the 18 week maximum waiting time from GP referral to definitive treatment
* Ensure that the most appropriate community-based treatment is offered based on clinical need, but where secondary care intervention is required, the surgical conversion rated are in line with national benchmarking
* To avoid unnecessary appointments and to design care which utilizes group settings and digital initiatives to maximise efficiency, clinical quality and outcomes
* To provide cost effective services, which maximises value for money and reduce the overall cost of MSK provision for the Hillingdon health and social care system.

**3.2.2 Care Planning and Condition Management**

* To provide rapid triage to ensure the patient is referred to the most appropriate sub-specialty to meet their needs
* To deliver a safe and high quality service which ensures rapid access to appropriate assessment, diagnostics (if required), early diagnosis, treatment planning and effective treatment, thereby controlling disease progression, maintaining health, and optimising wellbeing
* To ensure that following assessment a Service-wide customised treatment plan is created and implemented, and that this is transferred with the patient should they pass between specialties within the Service
* To help patients become active partners, together with the service, in developing the strategies that they will adopt in response to their condition – as detailed in a jointly developed Care Plan.
* To improve clinical care through the appropriate management of MSK conditions in line with NICE guidance and the MSK Services Framework (issued by the Department of Health in 2006);
* To utilise the CWHHE, and NWL agreed clinical pathway guidance, and support the development of further regional and local clinical guidance as required, to be used when triaging referrals and for providing advice to primary care clinicians on the management of patients with MSK conditions
* To build on skills and confidence of local GPs in the physical assessment; initial diagnosis and management of service users who are appropriate for primary care management aligned with our core pathways in general practice. This will be achieved through an ongoing annual programme of education and support
* To reduce the risk of co-morbidities associated with chronic pain such as depression, social isolation and loss of employment by ensuring that clinical pathways are aligned with mental health services to ensure a clear route of referral and support
* To provide evidence based information and support to enable patients to make informed decisions regarding their care, particularly when they are considering an escalation in their care from conservative to surgical management
* To provide patients with relevant and up-to-date information to enable them to independently manage their condition more effectively and thus reduce avoidable admission to hospital. This shall include, but not exclusively, returning to work and participating in education where appropriate
* To empower patients to take responsibility for their care through shared decision-making and goal setting
* To promote long term self-management and less dependency on the wider health care services such as A&E, GPs, Secondary Care, Ambulance Services and Mainstream Physiotherapy
* To support patients to attain a clear understanding of their condition and a realistic management plan, particularly in the context of persistent/chronic pain and long term conditions that are not suitable for and interventional/surgical approach
* To implement patient activation measures (PAMS) in MSK such as empowerment in self-care and best practice to new care model approaches including year-of-care for managing episodic and deteriorating MSK conditions, agreeing care plans with patients and creating shared goals
* To improve psychological well-being, social functioning, and the performance of everyday activities
* To ensure that when the service cannot directly meet patient’s needs, that they are actively signposted and referred to alternate support to meet their individual physical, medical, emotional and psychosocial needs.

**3.2.3 Care Planning and Medicines Management for Pharmacological Treatment**

* To provide a clinically safe and effective service to patients
* Enable key DMARDs to be prescribed and monitored safely in primary care by mutual agreement
* To provide therapy for stated, recognised indications for specified lengths of time
* To monitor patients’ therapy through their GP practice and/or preferred specialist provider/clinic, standardising the provision and use of blood test monitoring
* To take appropriate action if test results are abnormal
* To discontinue therapy when clinically appropriate
* As part of the Care Plan, promote the patient’s optimal use of analgesics and wherever possible to avoid dependencies.

**3.2.4 Service Improvement, Pathway Development and Enhanced Quality of Referrals**

* To work actively and collaboratively with GP consortia to support and advise on enhancing the management of patients within primary care and actively manage referrals to secondary care services
* To provide GPs with specialist advice and support to ensure that they can rapidly identify patients requiring early referral, but also focus on preventative treatment within primary care
* To interface seamlessly with referring GPs, other community services, local voluntary sector support groups and with a range of hospital based services to ensure direct and unencumbered patient pathway
* To have in place better opportunities for on-going training and development of healthcare professionals in primary care in the management of appropriate conditions
* To continually improve the service in response to feedback from patients, key partners or emerging practice
* To continually review and improve extended access, particularly for those in full time employment who may require evening or weekend access
* To contribute to the delivery of both NWL’s and Hillingdon CCG’s commissioning strategy and QIPP Plan.

### **3.3 Service Delivery**

**3.3.1 Proposed MSK Care Pathway**



**3.3.2 Service Leadership and Workforce**

The service will be clinically led by an appropriate senior clinician i.e. GP, GPwSI, Consultant Physician or Consultant Physiotherapist. If the service is not consultant-led, then consultant sessions must be provided in order to enable the assessment of patients who require an escalation in their care to an interventional/surgical approach, which will be delivered in secondary care. In addition, there must be senior triage and review of GP referrals for patients referred under the suspected cancer ‘2 week wait’ pathway. There must be a clear and accountable governance structure in place to ensure senior clinical accountability for the care provided by the service. In addition, there must be appropriate senior leadership at Service delivery locations to ensure the safe delivery of safe clinical services.

The remaining workforce will be a multidisciplinary team, and may include:

* Consultant Physicians (including pain management, Trauma & Orthopaedics and rheumatology),
* Extended Scope Practitioners (ESPs)
* Physiotherapists
* Clinical Psychologists
* Occupational Therapists
* Rehabilitation assistants, technical instructors, health care assistants
* Nurses and Specialist Nurses
* Sports and exercise medicine practitioners
* Administrators and service managers

**3.3.3 Conditions Treated**

The service shall treat the following conditions (not an exhaustive list):

* All arthralgia, myalgia (small and large joint, soft tissue, muscular pain)
* Spinal pain
* Mechanical arthritis e.g. Osteoarthritis
* Chronic regional or widespread MSK pain e.g. Fibromyalgia, hypermobility
* MSK related soft tissue lesions e.g. tendon injuries, ganglion, Dupytrens contracture, trigger finger
* Metabolic bone disorders e.g. Osteoporosis, Paget’s disease
* Peripheral nerve entrapments e.g. carpal tunnel syndrome
* Sports Injuries
* Rheumatologic conditions

**3.3.4 General Principles for Service Delivery**

* The service will provide a single point of access and triage, and will provide robust and effective assessment, diagnosis, treatment and care planning for adult patients of 16 years and older. For younger adults 16 – 18 years old requiring paediatric assessment or management, referrals will be rapidly directed to the appropriate paediatric services if required
* The Service will manage both routine and urgent referrals from a variety of sources, including for people with urgent ‘red flag’ presentations, and those referred by their GP to the suspected cancer ‘2 week wait’ pathway
* The Service will provide treatment for all patients with MSK problems, unless there is clear evidence following senior assessment that the patient would benefit from an onward referral to secondary care for an interventional approach or surgical procedure. Patients who are referred to secondary care must be referred back to the Service as soon as possible to receive any on-going care where this is clinically indicated
* The Service will actively work with primary care to improve referral quality where referrals do not contain sufficient information to allow the safe transfer of care from the GP to the Service. This may involve providing reports to explain decision-making and advice on further management
* Advice and support for GP’s will be provided to improve primary care management of patients presenting with MSK conditions. An ongoing programme of training and support will ensure that primary care can follow the agreed pathways when treating patients and only refer to the service when clinically appropriate to do so, by ongoing collaboration with GPs to check and balance referral guidelines, develop demand management strategies and improve feedback mechanisms
* The service will provide education and support for GPs to help them decide when the patient requires urgent referral to more specialist care, and when the patient would most benefit from remaining in primary care to manage their condition with an individual, mutually agreed care plan
* The service will work with GPs to ensure patients who no longer need access to a community service can be discharged promptly from the service and stepped down to on-going management in primary and/or self-care. This includes providing online and telephone advice and guidance to primary care clinicians. In this way, the service will work with primary care to empower general practice to reduce and prevent MSK conditions and keep patients healthier, for longer. The service will provide advice and guidance preferably via the preferred national eRS platform, and may also provide an email service as well as telephone. Enquiries should have a response time of 24 hours.
* The service will work with NWL STP partners to input into, and implement relevant care pathways. The service will proactively update local care pathways and clinical thresholds to ensure standardised care and reduce variation in outcomes across the Service
* The service will also keep up to date with developments and proactively propose updates to care within existing resource to improve quality and service sustainability. In addition, the service will be expected to engage with local education providers to undertake clinical research to enhance the clinical knowledge base

### **3.3.5 Access to the Service**

**3.3.5.1 Referrals**

* Referrals are made into the Integrated Community MSK Service via the single point of access (SPA) by GPs, Urgent Care Centre’s, Hospital consultants and other community AHPs e.g. Nurse Practitioners, rehab teams etc. Each referral should be completed on the single referral form (to be developed) containing the agreed minimum data set and be fully completed. Referrals are to be made electronically via the appropriate electronic method (TBC). The SPA admin team will undertake the following (this list is not exhaustive):
	+ Referral receipt/acknowledgment
	+ Check that minimum data set has been completed
	+ Booking and re-booking appointments
	+ Text reminders
	+ Operate a telephone queries line and email enquiry line
	+ Book interpreters
	+ Process discharge summaries and DNAs
	+ Collate activity data and statistics.
* The provider is responsible for ensuring that potential referrers are aware of pre-referral requirements and referral processes.
* The Provider is responsible for promoting high levels of referral quality and action any poor levels of quality directly with the referrer in line with the Service Model and the Hillingdon CCG Referral Returns Policy
* The service must make information available to the GP and other referrers (as per the pathway) and as a minimum this will provide a brief description of the service and how people can access it.
* Receipt and administration of all referrals will be the responsibility of the Provider
* The Provider shall ensure that any pre-referral requirements are clearly documented on eReferrals (previously Choose & Book)
* The Provider may decline a referral if the requested pre-referral requirements are not reported as complete on referral
* Referrals that are not appropriate for the service are to be returned to their source of referral within the triage timeframe with a clear explanation of why the referral has not been accepted. However, referrers are to be given the opportunity to add referral information to a referral, noting that it is current local GP practice to raise a routine referral during an appointment, then add/attach referral details/letter as part of administrative processes within 24-36 hours

The Provider shall ensure that referral arrangements do not cause a delay in access.

**3.3.5.2 Self-Referral for Physiotherapy**

* An option for patients to self-refer to physiotherapy should be available by year 2 of the provider contract
* Entry into physiotherapy will take place only via the SPA, and will require an administrative triage. The model for self-referral will be dependent on the provider and could be via a telephone advice line, referral form completed and submitted by the patient or a web-based questionnaire
* The patient will be clinically triaged and assessed by physical therapies, and if the referral is rejected, either from the SPA or from physical therapies, the patient will be informed by the service and asked to return to their GP for further consultation. An example self-referral form is shown in Appendix 2.

**3.3.5.3 Red Flag Referrals and referrals for suspected cancer (2 week wait pathway)**

**Referrals for patients with ‘red flags’ are to be excluded (?) from the Community MSK pathway and referrals should be made directly to the acute provider (to be confirmed). Red flags are detailed in the clinical pathways and include symptoms and signs that are suspicious of:**

* + **Suspected Cauda Equina Syndrome**
	+ **Suspected cancer (follow 2 week wait pathway)**
	+ **Patients with acute, rapid progressive or severe neurological deficit**
	+ **Trauma; acute trauma, suspected fracture, dislocation or infection**
	+ **Acute tendon rupture < 6 weeks**
	+ **Emergency conditions including but not limited to suspected septic arthritis, temporal arteritis**
	+ **Suspected organ damage related to an inflammatory rheumatic disorder or vasculitis (e.g. acute renal impairment, interstitial alveolitis, pericarditis, optic neuritis, digital ischeamia etc) or systemic disease causing toxic symptoms**
	+ **Inflammatory arthritis.**

**Patients with suspected cancer should be managed via the established via the 2 week wait referral pathway with referrals directed straight to the appropriate hospital service (to be confirmed).**

**3.3.6 Service Criteria**

**3.3.6.1 Inclusion Criteria**

* Must be 18 or over
* Must be registered with a Hillingdon GP and/or living in the Borough of Hillingdon (including patients residing in Hillingdon Nursing/Residential homes)
* Additional prompts for referral purposes should include:
	+ Primary Care Pathways and relevant investigations have been followed
	+ Referrals from GP to include a diagnosis where possible
	+ Patients may be referred from other secondary care MSK services
	+ Not be under another team/Provider for the same problem unless considered appropriate and core to the patient’s Care Plan

**3.3.6.2 Exclusion Criteria**

* Patients who do not have a suspected musculoskeletal condition
* Patients under the age of 18
* Patients not registered with a GP in the commissioning borough (unless a NCA (non contractual agreement) is in place)
* Patients requiring inpatient care / day-case services beyond simple procedures and outpatient infusion / injection treatments provided by the community MSK service
* NHS England Prescribed Specialist Commissioning Services
* Patients requiring home visits (domiciliary care is not provided by this service)
* Patients with red flags or suspected cancer (to be confirmed)

**3.3.7 Unregistered patients**

* Patients living in Hillingdon who are not registered with a Hillingdon GP Practice and who reside within the borough should not experience a delay in accessing care and will be supported wherever possible to register with a local GP practice.

**3.3.8 House-Bound Patients**

* The provider is not expected to deliver a domiciliary service, however they must make suitable transport provisions to support patient who have no other alternative transport arrangements (TBC). This may involve the organisation of transport at a cost to the service.

**3.4 Service Triage**

* All referrals will be received for triage by the service via the Service SPA, except red flags and 2 week suspected cancer referrals (TBC), where referrals should be made directly to the acute provider

**3.4.1 Administrative Triage**

* The provider will be responsible for ensuring an efficient and effective administrative process to support triage of referrals
* The referral will be acknowledged (e.g. via read receipt or alert) and will undergo a paper admin triage by the admin team to ensure the minimum data set has been fully completed
* Any incomplete, inappropriate or poor quality referrals will be returned to the referrer, except for those identified as urgent, which will be screened by a clinician to ensure the patient is not as risk as a result of a delay in acceptance of their referral.
* Where a referral is for physiotherapy and this is indicated on the form, as long as the minimum data set is met, the admin triage will re-direct straight to physiotherapy without the need for a further clinical triage

**3.4.2 Clinical Triage**

* Following successful admin triage, the referral will then undergo a clinical paper triage to allow the referral to be directed into the appropriate sub-specialty in accordance with agreed care pathways
* Clinical triage will be led by the Lead ESP/GPwSI/Consultant for the MSK community service and be carried out by appropriately trained and qualified member(s) of the MDT
* Triage should include assessment and/or advice, **as appropriate to the referral**, from subspecialties where appropriate e.g. consultant rheumatologist, orthopaedic consultant, pain management consultant, specialist nurse and/or Extended Scope Practitioner (ESP). For avoidance of doubt, the patient is not required to physically attend the Service for the Initial triage (i.e. the initial clinical assessment of the referral)
* Triage turnaround time is within **1 working day** from referral receipt for each triage point
* To ensure that care is delivered in the right setting, referrals to the Service will be assessed against primary care protocols to ensure that these have been complete before the patient is accepted to the Service. If it is established that further care can be delivered in the primary care setting, then the patient will be discharged back to their GP for on-going care with a report explaining the reasons for the decision
* The outcomes of the Clinical Triage will include, where appropriate:
	+ Prioritising and accepting urgent referrals, offering patients an appointment within timelines specified by the contract
	+ Appointment arranged for relevant sub-specialty
	+ Ordering diagnostic scans or blood tests for the patient, under the direction of the appropriate ESP or medical clinician, before the patient attendance at the service to see a specialist where appropriate
	+ Telephone assessment/consultation where clinically appropriate
	+ Onward referral for patients that are clinically appropriate straight to secondary care including Trauma & Orthopaedics, Rheumatology, Neurosurgery, Plastic Surgery or Pain service (for complex patients) to their preferred hospital
	+ Directing patients to other providers for MSK care where patient has expressed a choice of another provider
	+ Directing referrals to a range of other primary care services or providing signposting to other services
	+ Directing referrals back to the patient’s GP with advice for further work up and/or management where referral information is inadequate and appropriate clinical assessment cannot be made, or where primary care protocols have not been completed prior to referral
	+ Onward referral to other more appropriate services e.g. Podiatry, Dietetics.

**3.5 Booking**

* Booking is to take place following clinical triage into all sub-specialties and diagnositics
* Once triage has taken place there should be no delay in contacting the patient
* Service Users will be given adequate notice and a choice of appointment
* Waiting times following referral receipt to first appointment offered to patient must not exceed;
	+ 2 weeks for urgent interface service and physical therapies,
	+ 4 weeks for patients triaged to interface service, and,
	+ 4 weeks for patients triaged for a routine physical therapies appointment.
* A choice of appointment days and times will be offered and patients will have the option of booking appointments outside of the two or four week period for eventualities such as holidays.

**3.6 Assessments and Care Planning**

* At the first appointment the Service will utilise physical and mental health outcome measures and accepted assessment tools to establish the severity of the condition and the need for treatment by the Service beyond that which can be provided in primary care
* Individual patient capability will be scored on a self-activation spectrum during initial assessment to ensure that patients are empowered to take control of their care and sustain their health
* Patients will have their diagnosis, condition/problem, treatment pathway, and prognosis explained to them at their first appointment
* The patient will be involved in shared decision-making, including the development of a care plan with joint goals and which supports ‘realistic expectations’ of what can be achieved
* The care plan will outline the prescribed number of follow-ups and an outline of what further treatment, if any, the patient requires
* The care plan will include activity prescription and social activation where this is appropriate to meet the patient’s needs
* Discharge planning will be incorporated into the care plan, and a copy of the care plan will be provided to the patient and their GP providing relevant information about managing their condition and providing clear signposting to other appropriate services
* A copy of the care plan will be provided to the patient and their GP
* Patients will have treatments and alternatives explained in understandable terms in order to provide the necessary information for patients to choose the treatment option and location that most closely aligns with their unique personal situation
* Treatment, education and advice may be offered on a 1:1 or group basis as appropriate to the patient’s needs
* Diagnostics may be directly requested, including MRI.

**3.7 Treatment Provided**

MSK disease management and treatment will be provided by the sub-specialties within the Service.

**3.7.1 Patient Self-Care**

* Patient self-care must be promoted throughout assessment and follow up care
* It should consist of thorough education and supported self-management plans
* A variety of tools and techniques should be utilised to support patients in understanding their condition, what their treatment plan involves, and their role in their care and recovery
* A specific focus on patient support and care planning for patients with long-term conditions is essential
* On discharge from the Service, patients and their GP will receive an on-going care plan which describes the patient’s future self-care plan post-discharge from the Service
* The care plan should be developed jointly with a patient, and be inclusive of maintenance, exercise and other relevant advice e.g. diet advice
* More complex patient’s care plans may be uploaded on to a shared care record system with access by secondary care with the consent of patients.

**3.7.2 Chronic Pain Sub-Specialty**

* MSK Chronic pain has been defined for the purposes of this specification as pain relating to, or resulting from, a musculoskeletal condition or disorder that persists for longer than 3 to 6 months, or beyond a reasonable healing time for an injury or treatment
* The provider is responsible for providing an integrated MDT approach to chronic MSK pain management within the Service
* Early recognition of sub-acute and chronic neuropathic pain and prompt specialist review is mandatory
* The community service would be expected to refer to secondary care where appropriate
* Secondary care will manage more complex cases, patients who have failed initial therapies, those with high Opioid demands and those requiring specialist diagnostic procedures and interventions
* It is expected that a small proportion of patients will be referred to hospital care for specialist interventions
* Within the chronic pain sub-specialty, the Provider is required to provide:
	+ Prevention strategies
	+ Pain assessment and care planning with patients
	+ Supported self-management; sign posting patients to self-help resources and support groups
	+ Pharmacological management
	+ Psychologically based interventions; pain management programme within the Service should be considered for patients with chronic pain
	+ Physical therapies; exercise and exercise therapies, regardless of their form, are recommended in the management of patients with chronic pain
	+ The Provider will need to integrate with specialist pain management services in hospital to facilitate direct referrals for specialist interventions. Referrals to hospital pain services may include patients who have failed initial therapies, those with high Opioid demands and those requiring specialist diagnostic procedures and interventions
	+ There should be close integration with multidisciplinary spinal pathways, which will involve specialist Spinal surgeons, pain physicians, psychology and rheumatology

**3.7.3 DMARDs Sub-Speciality**

* The service shall have the capability to assess, manage and monitor patients receiving targeted biological therapies
* The service shall ensure that patients have access to medicines use reviews and will have the ability to review and optimise medication use, with the objective of ensuring appropriate and cost effective prescribing
* The list of DMARD drugs will be reviewed periodically and additional drugs may be added or removed from the shared care agreement protocol with agreement form all parties
* Practice based GPs may carry out monitoring and prescribing responsibilities for patients on DMARDS that have been identified by a rheumatology specialist as being stable and care shared with primary care- See the SCA for further details
* For patients on biological therapies, education and advice will normally be conducted by the specialist during initiation and stabilisation
* The Provider must also ensure that all patients currently prescribed DMARDs (and/or their carers when appropriate) receive or have received appropriate education and advice on their condition and the medicines used to treat it. This should include written information where necessary on the:
	+ Frequency of blood tests and importance of continued regular monitoring
	+ Management and prevention of secondary complications of their condition
	+ Emergency contact details in the event of a concern or complications
* The provider will monitor patients’ disease and review their condition as follows:
	+ Measure CRP and key components of disease activity (using a composite score such as DAS28) regularly in people with RA to inform decision-making by Rheumatologists about future care of the patient.
* Offer people with satisfactorily controlled established RA review appointments at a frequency and location suitable to their needs (including an annual review). In addition, make sure they:
	+ have access to additional visits for disease flares,
	+ know when and how to get rapid access to specialist care, have ongoing drug monitoring.

**3.7.6 Physiotherapy and Rehabilitation Sub-Specialty**

* Clinical assessment will be conducted based on the principles of musculoskeletal physiotherapy to ascertain the patient’s suitability for physiotherapy
* Following assessment, a Physiotherapy Care Plan will be developed based on the assessment findings
* MSK physiotherapy treatment will be provided as clinically indicated, including mobilisation, manipulation, splinting, taping, electrotherapy and education informed and supported by research evidence, hydrotherapy (where available)
* Provision of appliances/orthotics
* Fitting service (including holding a supply) for splints
* Therapeutic exercise and functional rehabilitation
* Electrotherapy
* Self-management advice, lifestyle and health promotion advice including; dietary advice, exercise promotion, signposting and coordination with other services e.g. mental health support, health trainers, expert patient programs
* Physiotherapy-Direct telephone assessment/treatment which is expected to be in place in year two of the provider contract
* Osteoarthritis knee school and other appropriate class-based interventions
* Core stability/clinical pilates exercise classes
* Early assessment clinics for acute soft tissue injuries
* Women’s health physiotherapy
* Possible inclusion of other evidence based/ ICE approved physical therapies (with agreement from the commissioner)
* Referrer support, training and advice in the management of MSK conditions in primary care.
* Specified evidence-based programmes of care for various problems e.g. Escape Pain

**3.7.7 MSK CATS- Consultant and/or ESP provision Sub-Specialty**

* MCATS clinics delivered by ESP’s/consultants for the expert assessment, diagnosis and management planning for complex MSK problems
* Assessment for suitability and delivery of peripheral soft tissue joint or steroid injections
* Screening of patients who may need secondary care intervention
* Direct referral for investigations (MRI, US, Xray, EMG/ NCS, bloods)
* Streamlined onward referral into secondary care if necessary
* Referral to MSK Physiotherapy and other services such as podiatry
* Self-management advice, reassurance and explanation

**3.7.8 Trauma and Orthopaedics Sub-Specialty**

* MSK Medical clinics will be delivered by MSK GPwSI/consultants/Physiotherapy consultants to provide complex assessment, advice, interventions, and may include secondary care clinicians if onward referrals are required
* Consultant-led MDT meetings will be held to discuss complex cases and make future management decisions which may result in onward referral for surgery or other intervention
* To provide specialist treatment and rehabilitation for adults with complex and/or rare orthopaedic conditions
* To ensure specialised orthopaedic services are delivered by the appropriately trained and resourced multi-disciplinary team to improve outcomes for patients and reduce avoidable complications and costs.

**3.7.9 Rheumatology Sub-Specialty**

* Rheumatology medical clinics will be delivered in accordance with agreed clinical pathways
* Provision of assessment and treatment of a range of rheumatologic conditions as well as advice and guidance on managing these conditions
* Conditions may include (but are not limited to):
	+ Ankylosing Spondylitis
	+ Osteoarthritis
	+ Polymyalgia Rheumatica
	+ Psoriatic Arthritis
	+ Rheumatoid Arthritis
	+ Sjogren's Syndrome
	+ Spondyloarthritis
	+ Systemic Lupus Erthematosus (SLE)
* All of the above will be delivered in line with robust current research evidence, NICE publications, and Department of Health guidance.

**3.7.4 Prescribing**

* The Service must provide patients with prescriptions for new medications or amended doses (or provide a supply if the Provider has the legal and supply framework for this from the Service locations)
* At least 28 days of supply should be prescribed to allow information to be provided to the GP regarding the outcome of the appointment and any changes in medication (initiated, dose changes, terminated) to be communicated in time for them to prescribe any required on-going medication to the patient
* Where patients are required to be stabilised on treatment before prescribing is transferred to a patient’s GP (e.g. DMARDs) the Provider will be responsible for prescribing and monitoring of the patient until this time, in line with local shared care arrangements
* The Service must comply with the North West London Integrated Formulary and the local Management of Infections Guidelines and any other relevant guidelines that the CCG will provide as appropriate and relevant to the service
* The Provider will be responsible for all prescriptions including prescribing ‘North West London Red Drugs
* The Provider must ensure the safe and legal storage and disposal of medicines and prescription.

**3.7.5 Diagnostics**

* The provider will be expected to include Diagnostics within their service contract
* The provider may utilise existing Commissioner service level agreements (SLAs) for accessing provision of imaging, including any designated private provider, and secondary care
* The provider must maximise efficiencies where possible, such as referring to the most cost-effective provider for imaging, whilst taking into consideration patient choice
* The provider will be required to review, follow-up on results and ensure appropriate action is taken within 1 working day of receipt of results. This process will be stipulated in the agreed Diagnostics clinical guidelines and policy including auditing process to ensure that all staff notes and records are audited within a yearly cycle
* Any unnecessary delays in receiving results from diagnostic services must be reported to the Commissioner and recorded and monitored within the Provider’s tracking system
* Principles for use of MRI in the community service are designated as follows:
	+ Requests for MSK MRI must be sent via the MSK community service. The patient is to be seen face to face before an MRI is requested. They should be assessed, against the Royal College of Radiologist guidelines
	+ The preference for location must take into account patient choice
	+ If the MRI is being requested prior to and as a requirement for surgery then the MRI should be completed by the provider who is likely to be carrying out the surgical procedure, to ensure the images are at the correct standard for the surgeon
	+ If the MRI is being requested to exclude a condition prior to continuing therapy then the report should be approved by MSK radiologists
	+ Images and reports are to be transferable and accessible to community and acute providers.
	+ Reports are to be embedded into the image
	+ In exceptional circumstances, MRI scans are to be provided in absence of patient NHS number with clear clinical justification
	+ The Service will send recent MRI images on to acute provider electronically via the diagnostic provider and include an electronic link where record is held on diagnostic cloud
	+ Urgent scans should be available as a matter of clinical discretion. Examples of where this might be appropriate include red flags that were not suspected at the time of referral, severe pain refractory to adequate and appropriate analgesia, clinical deterioration where urgent imaging is important to determine diagnosis or management.

**3.8 Follow-Up Appointments**

* The service is expected to implement a system to enable virtual follow-ups (i.e. via telephone, text, email or other platform) to check in on patient progress and prevent unnecessary face-to-face re-attendances to the Service or other care providers in the wider pathway
* Following assessment, all treatment should adhere to clinical guidance.
* Should the patient require more than 6 treatment sessions (includes the initial assessment), contact should be made with GP for consultation before proceeding with further treatments if felt necessary by the therapist. This would involve telephone or email contact between the therapist and the GP.

**3.9 Discharge Criteria**

**3.9.1 Acceptable discharge criteria:**

* + MSK problem resolved
	+ Optimum outcome following treatment/ advice achieved
	+ Patient able to self-manage
	+ Patient able to manage condition with exercise programme
	+ Patient failed to attend for initial appointment or full course of treatment in line with the Service DNA policy (to be agreed with commissioner)
	+ Patient declines to participate in recommended evidence based management
	+ Patient requires referral to another discipline or back to original referrer
	+ Referral back to GP for further management with advice
	+ Patient discharged for requested second unbiased opinion.

**3.10 Information provided to GP on discharge:**

* + Patient identifiable details (patient number / name)
	+ Date of attendance and discharge
	+ Investigations carried out
	+ Summary of findings (including diagnosis)
	+ Information provided to the patient
	+ Management plan
	+ Medications initiated or terminated; and
	+ Follow-up arrangements.

**3.11 Onward Referral to Secondary Care**

* Direct referrals can be made from the Service to secondary care for MSK related conditions where this is clinically justified
* In order to refer patients to secondary care, 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 where appropriate and where arrangements are in place and patient choice is offered;
	+ All diagnostics results and patient notes under agreed information sharing arrangements with hospital providers to prevent diagnostics duplication
* Patients that are deemed appropriate candidates for referral to secondary care should have the likely outcomes of the referral and further treatment explained to them before the referral is made in the interests of reducing inappropriate referrals to secondary care and increasing surgical conversion rates. Patients should be given time to reflect on their options, and a virtual telephone follow-up organised to confirm their choice before a referral is made. Should the patient choose to be referred to secondary care, they should be advised that they are free to change their mind and receive the alternative to surgery
* The Service must put in place a Trusted Assessor referral model i.e. the Service will complete the surgical workup for appropriate patients with the aim of reducing discharges after first appointment in secondary care
* All referrals, to secondary care whether from a GP or other health care professional, will be treated as a GP referral for the purposes of delivering a maximum 18 week referral to treatment wait
* The MSK SPA should work with the hospital to ensure patients have an appropriate length of stay, and proactively support patient discharge by reviewing patient discharge support needs before the referral is made, including consideration of any post-surgical impairment that may restrict mobility or function. If this is the case, liaison with Social Care should occur in advance where possible to ensure the appropriate support is in place on discharge. Appropriate arrangements should be made prior to admission to hospital in order to streamline the discharge process post-surgery/procedure
* Where unplanned needs and/or procedures arise during the hospital stay, this information should be entered into the Service care plan and the service should assess whether this could have been prevented. Patient cases like these, and others, may be shared with the relevant Clinical Working Group (CWG) to help improve system working
* It is expected that the Service will undertake any post procedure/intervention/surgery follow-up as would normally be undertaken by a secondary care consultant. This will enable a reduction in unnecessary hospital-based follow up appointments for patients
* The service will offer patients direct access to the service after initial referral and/or after a period of time from discharge, whereby patients can access “maintenance” interventions. Note that patients being offered “maintenance” interventions should demonstrate a concurrent reduction in demand for other services/resource/medication usage
* When discharging patients, the Service will provide access to other support services such as social services (e.g. benefits support), housing and voluntary sector services. The service will ensure there are links with employment support services which can help those patients whose condition affects their working life
* The Service is expected to develop clear pathways and processes for rapid onward referral of patients where there is suspected malignancy in line with the suspected cancer ‘2 week wait’ pathway. Under these circumstances, the provider is expected to follow up receipt of the referral to ensure it has been received and acted upon
* The Service must have in place pathways and processes for urgent referral to A&E for emergencies e.g. for patients with red flags requiring urgent admission

## 3.12 Discharge from the Service

### **3.12.1 Discharge Protocol**

* Patients will be discharged with a clear care plan which includes information on how to self-manage their condition, how to access free/low cost services in the community and how to gain future access to the service, if appropriate.
* The provider will ensure that it works collaboratively with stakeholders in the local health economy to develop shared care pathways, joint working and clear handover points across primary and secondary care, keeping GPs informed about the patient management plans which is essential
* GPs will need to be sent discharge letters within 3 days of the patient being discharged to primary care
* On referral to secondary care, the care plan should also be shared to support a shared understanding of the patient’s expressed needs and goals. The referring clinician should also make themselves available to discuss the referred patient’s condition with secondary care consultants if necessary to inform clinical decision making
* Prescribing of any other medication required for 4 weeks or less post discharge will be provided as part of the service and will be included in the contract tariff price. If treatment is required for greater than 4 weeks, the service provider will be required to communicate with the GP for on-going prescribing

**3.12.2 Record Sharing on Discharge**

* Where more than one organisation is involved in the provision of services, there must be clearly defined responsibilities with respect to the transition of patient data
* These responsibilities must be clearly aligned to the commissioner intention for integrated care, which is that, regardless of how many provider organisations are involved in delivering the service, patient care across the service is treated as a single episode of care
* Also to be considered are the processes necessarily related to record keeping and period of retention of patient records in alignment with NHS protocols.

### **3.12.3 Discharge for Non-Attendance (DNA) (for agreement with the provider)**

* Where a patient fails to attend an initial appointment, it will be the responsibility of the service to provide the patient with one further opportunity to attend an appointment
* The patient should have the opportunity to change the date and time of the appointment if unable to attend the allocated time
* Should the patient not attend this second-initial appointment, it will be the responsibility of the patient to rebook another appointment
* Failure to do so within the four weeks after the second-initial appointment date will result in discharge
* The patient and their referrer/GP should be informed of failure to attend an initial appointment, including the date and time of the second-initial appointment booking, as well as the patient’s responsibility to attend or rebook within four weeks after non-attendance.

### **3.12.4 Patient Communication, Education and Advice**

* At the point of discharge from the services patients will receive a personalised summary that should include their care plan, as well as the following:
	+ Any other self-care advice
	+ Any direct referral or booking information including the time of appointment if provided with the address details including post code
	+ Any information on services for self-referral
	+ Other onward referral
* Is it the intention for patient communication to have a person-centered approach, and where possible include a face-to-face meeting and a physical letter as SMS and email may not be accessible for all patients.

**3.12.5 Coordination with Primary Care**

* The engagement and support of local GPs will be vital to the success of the Service, and the provider must work effectively with local GPs and GP networks, by
	+ Keeping GPs informed about the diagnosis, care provided, plan for on-going care, expectation of practices in primary care (including review dates)
	+ Support GPs / GP networks to develop primary care MSK leads
	+ Ensure adequate medication information is provided at discharge from the service to support medication review by local GPs and pharmacists
	+ Involve clinical networks in the on-going development of services
	+ Involving primary health care teams in delivery of care (including shared care arrangements)
	+ Education and skills development of GPs and the wider primary health care team, and support for condition management in primary care
* The new service will be accessible for local GPs, who will be able to ask for advice and guidance via email (or through an arranged phone call) before or instead of referring a patient
* Elements of primary care management should be managed across the GP networks – with appropriate annual training and validation provided for clinical leads from practices/networks
* Management of MSK conditions to be considered in primary care are detailed in the clinical pathways and will include;
	+ Pain management and drug therapies as appropriate according to national guidelines and agreed clinical pathways
	+ Patient education, lifestyle and exercise advice
	+ Carpal tunnel wrist splinting with over the counter splints or first line splints to be provided by the MSK Community service

**3.12.6 Information Technology**

* The Provider will be expected to demonstrate that its core clinical system and business processes meet the requirements below and that an appropriate and robust IT infrastructure is in place to support this. These should include:
	+ A robust and resilient IT infrastructure for virtual appointments and records
	+ A fit for purpose core clinical system
	+ Adequate and secure access to clinical systems
	+ Full compliance with Information Governance
	+ Robust Business Continuity and disaster recovery plans and processes
	+ The Provider will be expected to demonstrate that its core clinical system and business processes meet the requirements below and that an appropriate and robust IT infrastructure is in place to support this
	+ The provision of this service will be significantly dependent on the use of Information Management Technologies in support of integrating information and business processes in support of care delivery. This innovation aims to place the patient at the centre by making all relevant information on the patient available by appropriate sharing and fast, safe and efficient ways of communication with all clinicians in the local health economy
* The provider will be required to use an IT system that is interoperable with that used by GPs in the borough of Hillingdon e.g. StstmOne or Emis (TBC), and to interact with other electronic systems in Hillingdon such as CMC as appropriate to patient care
* The Provider(s) shall adhere to the national interoperability with locally determined functionalities and standards that are in force at the time of this procurement and future updated standards (National and Local) which may be varied from time to time
* The service should be mindful that under GP system of choice that the GP system landscape can change rapidly and the service should be able to integrate with any of the menu of systems as stipulated by HSCIC. The Provider will need to interface with the application stated following the guidance of the ITK
* Any costs for achieving interoperability will be borne by the provider
* 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 Central London CCG’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 (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
	+ Interaction with Coordinate My Care (CMC) record
	+ Ability to share and view agreed data sets from all systems listed above e.g. Care Plans, patient status alerts
	+ Ability to book appointments directly into other local systems
	+ Ability to send/receive defined and agreed tasks including notifications to/from other local systems and clinicians
	+ Ability to send text messages from within the system
	+ Ability to electronically pass on referrals to other local clinicians clinical systems
	+ Ability to integrate and or interface with the Directory of Services.
* The Provider(s) will also need to ensure their system(s) have the interfacing capability to view, retrieve in real time, store and remove notes that were not generated in EMIS, where applicable on a case by case basis (i.e. interoperability with System One, HCR, CMC). The number of notes this applies to will change during the life of the contract. Access to these records and databases will require a number of systems or gateways including but not limited to:
	+ Adastra
	+ Cerna
	+ Summary Care Record
	+ Medical Interoperability Gateway (MIG)
	+ Child Protection Information Sharing (CP-IS) system
	+ Co-ordinate my Care (CMC)
	+ Pan-London PRM cloud-based solution supporting integrated record sharing.
	+ Access Special Patients Notes (SPNs) for Out of Area patients as and when they are made available;
	+ Previous encounters data base
	+ Mental Health Crisis Plans
	+ Dementia
	+ Agreed emergency care / Crisis plans

**3.12.6.1 System Wide Clinical Record**

* The provider must ensure that the patient record is share-able with clinicians across organisational boundaries, where appropriate, to support patient care
* The shared care record will include flags for re-referral into the service, as well as discharge indicators to prevent ongoing patient follow-ups between clinical staff and ensure patients progress along the pathway at each appointment
* The service should strive to ensure no patient is ‘lost’ between services after discharge and maintain a robust handover policy supported by the appropriate IT systems
* The main systems used across primary care within Hillingdon are EMIS and System 1
* The main system used within the boroughs secondary care services is Hillingdon Care Record (HCR) which includes access to CMC, EMIS, pathology, radiology reports, discharge summaries and outpatient letters
* The aim across NWL is to ensure that where patients have a Care Plan in place that they are treated in accordance with the plan. To support this aim all clinicians should have access to relevant aspects of a patients’ care records, where the patient has consented to this being available.

**3.12.6.2 Directory of Services**

* The Directory of Services (DoS) provides access to service information, which is a critical element of integrated care coordination.
* The provider(s) IT system will need to be able to interrogate the DoS/MiDOS to identify the local service best able to meet the patient’s assessed needs and present a list of services to Health Advisers and Clinicians
* The DoS returns will clearly indicate the agreed local referral protocols for each service and the message to relay to the patient will indicate the agreed approach to local clinical assessment i.e. whether the local service accepts the type and timescale of the disposition or accepts the type and continues the assessment locally to agree the timescale and setting for any further patient contact (advice, appointment or visit)
* All clinicians will need to access the mobile DoS (MiDOS) to identify the most appropriate service to refer patients to.

**3.12.6.3 Innovation**

* Commissioners are seeking innovation in the introduction of new technologies and ways of working that may enhance the Service over the term of the contracts for the Service(s) to enrich patient experience, which will support the wider urgent care system.

**3.12.7 Locations of Service Delivery**

* The service will be provided in at least three locations in the northern, mid, and southern localities of Hillingdon
* There should be some flexibility with regards to locations, days, times and sessions held (e.g. extended hours) to reflect modern working commitments and to encourage maximum levels of attendance is supported
* The service would also be strengthened by co-location at GP practices and/or hubs, as well as The Hillingdon Hospital. The adjacency of the teams can influence the degree to which they communicate effectively, improve patient experience, and clinical decision-making.

### **3.12.8 Hours of Operation**

* The service will be operational between the hours of 7am and 8pm Monday to Friday, and Saturday morning between the hours of 8am and 1pm
* The Provider must show that it proactively engages its patients for feedback to justifying the hours it is operating and capacity at locations given referral and treatment trends
* Patients are expected to be involved in the decision making for opening times and the service will show how this has been done. The service will be monitored for patients’ opinions on their appointment times, including the ease of booking and flexibility.

### **3.12.9 Response Times and Prioritisation**

* The service will triage urgent referrals within 2 calendar days of referral and the patient will be seen within 2 weeks
* Routine referrals will be assessed within 6 days of referral and the patient will be seen within 4 weeks
* Referrals for patients with suspected cancer and red flags should be triaged within 24 hours and seen within 3 days of referral.

### **3.12.10 Whole System Relationships**

* The service shall offer an integrated model of service delivery and shall utilise the skills of other Providers external to this service
* Any contractual relationships established will be the responsibility of the Provider
* Below is a table highlighting the key relationships and how these could be utilised. The list is neither prescriptive nor exhaustive and providers will be asked how they would configure and utilise whole system relationships.
* The service(s) will be interdependent with Secondary Care MSK service Providers
* The service provider should therefore ensure it has an effective understanding of all the Providers working within the trauma and orthopaedic, and interventional pain pathway(s) and be able to establish operational links with each service to ensure smooth transfers of patients.

|  |  |
| --- | --- |
| **Provider/Key Relationship** | **How Utilised** |
| GPs | Working with GPs to ensure good quality of referrals/ good understanding of the service and how GPs can actively manage patients once discharged. |
| Other MSK Services | Establishing close links so that referrals that are directed via their GP from MSK services are appropriate and timely. Ensuring patients understand their transfer of care. |
| Secondary Care Specialist providers | Establishing close links so that any specialist interventions needed (for patients not within the remit of the specification) can be conducted quickly and effectively and patients transferred back into the service as soon as possible where appropriate. |
| Independent Sectore.g. gyms | Establishing links with independent sector Providers, working with them as part of a package of care to delivery of parts of the pathway not within the capacity of the service e.g. access to gym equipment / swimming pools etc. |
| Local Authority e.g. leisure services / benefits | Establishing links with Local Authority working with them as part of a package of care to ensure delivery of parts of the pathway not within the capacity of the service e.g. access to gym equipment / swimming pools and utilising the range of services LA have at their disposal e.g. benefits advice etc. |
| Employment advice services | Establishing links with benefits /employment agencies to ensure that the patient’s condition is not a barrier to returning to or finding employment |
| External physical and mental health patient support groups | Using external support groups to compliment the pathway of care and ensure patients have access to longer term support |
| External pain/patient support groups | Using external support groups (with different expertise in rheumatologic conditions) to compliment the pathway of care and ensure patients have access to longer term support |

### **3.12.11 Minimum Governance Requirements**

# 3.12.11.1 Clinical Governance

* The Service be must supported by a robust framework for clinical and information governance, managed by an appropriately experienced and governed provider
* There should be a clearly documented process to support the management of the MSK service
* The Provider must be registered with the appropriate regulatory bodies, including the CQC
* The service will operate within an agreed, standardised CQC clinical governance framework that will meet regulatory requirements and work towards maintaining and improving the quality of care that patients receive from all elements of the service
* The governance framework will include clinical audit, call auditing, sharing of good practice and ideas, as well as work to address poor clinical performance. Information about patient’s care and service outcomes will need to be routinely collected and monitored and provided to the commissioner on a timely basis. This will include assessments, diagnosis, referrals to other services and the management of patients with cancer and/or chronic long-term conditions
* In addition to those referenced within the main body of the standard contract, the provider should have policies covering:
	+ Infection control procedures
	+ Needle-stick injury management (including access to fast track management)
	+ Clinical Waste Management
	+ Health and Safety
* The service will ensure that clinical information is recorded and share-able to enable consistent, safe and high quality clinical care. Consent to view records should be obtained at each patient’s first consultation and documented in their patient record. Additionally all calls should be recorded on the system
* Complaints and concerns will need to be dealt with by the provider providing the service, and need to follow the provider’s published complaints policy
* Complaints and compliments involving the service will need to be shared between the provider and the commissioner as part of contract monitoring
* The provider should ensure that the service is delivered from a suitable location and clinical room, that has been risk –assessed to assess for the risk of collapse and any other reasonable foreseeable circumstances
* The service should be provided in a room with a couch, sink and panic alarm system
* If required to ensure that the service is operating effectively, the commissioner can interview the service provider's staff
* Health promotion activities can be promoted to patients as long as there is no cost attached to a patient in taking up these activities.

**3.12.11.2 Clinical Accountability**

* The Provider will be expected to develop an infrastructure of clinical management and leadership, ensuring that all governance requirements have the relevant clinical leads. The service should have a designated and accountable Medical Director/Clinical Lead who has MSK care experience.
* Whilst the overall clinical responsibility of the patient resides with the registered GP, the designated Clinical/Medical Director will take responsibility for the practice of all staff that treats patients autonomously. The Clinical Director also will take responsibility for the development, approval and implementation of care pathways and protocols.
* The provider shall be clinically responsible for the episode of care that is administered to the patient, and they shall be responsible, and accountable, for all aspects of the work of the Services staff. This includes the management of patients in accordance with the GMC, NMC, Health Care Professionals Council, Chartered Society of Physiotherapy and College of Osteopathy codes of ethics and rules of professional conduct
* There must be clear and accountable governance arrangements with senior clinical leadership to provide accountability over care provided within the Service with appropriate presence at Service delivery locations
* The Clinical/Medical Director will meet on a monthly basis, with the CCG nominated clinical lead, to review the clinical governance arrangements and undertake the provision of a monthly report. The format of the reporting will be mutually agreed with the CCG.

**3.12.11.3 Workforce Competency**

* The provider must ensure that all staff delivering the service are competent to do so
* There must be an appropriately qualified health care professional, named as the service lead who has overall responsibility for ensuring the service is delivered in accordance with the specification
* It is the responsibility of all staff delivering the service to remain up to date with all relevant training requirements. Members of staff that have been out of clinical practice for an extended period (e.g. 1 year) should seek guidance from their appraiser and/or relevant professional body regarding appropriate re-training.
* Staff delivering the service must be trained on all appropriate policies relating to the delivery of the MSK service
* Staff undertaking any procedures must have verified Hepatitis B protection
* Staff undertaking any procedures must be CPR trained (adults) when they start to provide the service and should attend annually thereafter.
* Adhere to national recommendations and requirements regarding education and training

**3.12.11.4 Education and Training**

**3.12.11.4.1 Staff and Peers**

* It is expected that the service will provide education, training and research support to the wider health economy with the following being the minimum requirement:
	+ Provide appropriate levels of access to training, education and research for the staff it to a high quality
	+ Provide education and training to GPs, so that the pathways for this and other elements of MSK services are clearly differentiated and appropriately adopted. No additional payment/tariff for this element is available. This is expected to include the offer to all Hillingdon GPs of at least three training events per year.

**3.12.11.4.2 Patients, Carers and Public**

* The provider is expected to work with patients to support health promotion and awareness of services, and to identify opportunities for increasing awareness to encourage greater discussion in the community about self-care and prevention of MSK conditions.

**3.12.11.4.3 Information Governance**

* The Provider shall adhere to all NHS standards for Information Governance and be compliant with the Information Governance toolkit, achieving a minimum of level 3. The Provider shall evidence robust plans for maintaining and improving achievement
* The Provider will also be required to ensure that all staff login with Smart cards and that their system(s) connect with the NHS Spine
* The Provider will demonstrate full compliance and registration with CQC
* The Provider will ensure that all information sharing guidelines and protocols are abided by to maintain the safeguard of service user identifiable data. The Provider will take account of:
	+ Data Protection Act requirements;
	+ NHS Code of Confidentiality;
	+ The CCG’s information governance policy
	+ Informed consent; and
	+ NHS Connecting for Health’s care records guarantee.

If there are any concerns regarding the safe transfer or use of service user identifiable data, then these should be reported as a Serious Incident and referred to the local Caldicott Guardian

* Data generated in the course of delivering the service should be available to the commissioner on request. The commissioner will give due regard to data protection and confidentiality requirements.

**3.12.11.4.4 Patient Engagement and Experience**

* The Health and Social Care Act (2012) underlines a commitment to put patients at the center of care delivery by providing them with better information, more choice and a stronger voice
* All major policy drivers make it clear that good practice in patient experience must be embedded, for example a patient panel, in reviewing the service so that the views of patients and the public are heard and inform decision making
* The NHS Outcomes Framework 2011/12 sets out a clear framework for driving improvement in the quality of patient experience and outcomes. Alongside the Framework sit the Care Quality Commission’s Essential Standards which outline how the NHS can provide the services and experience that patients expect.
* 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
* 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 centered 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
* All patient engagement should form part of an audit trail to ensure the quality, transparency and integrity of the process.

**4. Applicable Service Standards**

The service will be delivered subject to the following standards. This is not meant as an exhaustive list and the supplier should take steps throughout the contract to remain aware of relevant legislation and standards and will be required to work within the standards set by these:

## 4.1 Applicable National Standards

The service is expected to work to national standards and stay abreast of relevant developments.

* High Quality Care For All, DH, 2008
* The Musculoskeletal Service Framework - A joint responsibility: Doing it differently, DH, 2006
* Delivering Quality and Value – Focus on Musculoskeletal Interface Services, NHS Institute for

 Innovation and Improvement, 2009

* The ‘Getting it right first time’ (GIRFT) report. Professor Tim Briggs (2012).
* Delivering Quality and Value – Focus on Magnetic Resonance Imaging (MRI) and Low Back Pain, NHS

 Institute for Innovation and Improvement, 2008

* Delivering Care Closer to Home: Meeting the Challenge, DH, 2008
* Arthritis and Musculoskeletal Alliance Standards of Care, ARMA, 2007
* Our Health, Our Care, Our Say – A New Direction for Community Services, DH, 2006
* NICE Guidance – Osteoarthritis: The Care and Management of Osteoarthritis in Adults, 2008
* 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
* The related Technical Appraisals and Interventional Procedure Guidance for

 Musculoskeletal/Rheumatological conditions

* Applicable National Service Frameworks (Long-term Conditions, Older People)
* Guidelines for GPs with a Special Interest (GPwSI): Musculoskeletal Conditions, RCGP, 2003
* The NHS Operating Framework for England, 2015/16, DH
* Care Quality Commission Core Standards
* The Chartered Society of Physiotherapists – Core Standards and Service Standards, CSP, 2005
* Making the Best Use of a Department of Clinical Radiology, Guidelines for Doctors, 5th Edition, RC

 Radiologists, 2003

* Standards of care for people with musculoskeletal conditions, ARMA, January, 2004.
* The Musculoskeletal Framework, Department of Health, July 2006. Perceptions of patients and

 professionals on rheumatoid arthritis care, The Kings Fund, January 2009.

* The management of rheumatoid arthritis in adults, NICE, February, 2009.
* Services for people with Rheumatoid Arthritis, National Audit Office, July 2009.
* Expert Opinions in Rheumatology: Issue 2 The PCR Society Guide to Commissioning Musculoskeletal

 Services (Sept 2011).

* The State of Play in UK Rheumatology. Insights into service pressures and solutions BSR & BHPR

 (2015).

* NICE Guidance: Specifying a service for people who need biologic drugs for the treatment of

 inflammatory disease in rheumatology, dermatology and gastroenterology. (2012).

* Department of Health (2009) 18-week Commissioning Pathway for Chronic Pain
* Department of Health (2010) Essence of Care 2010 Benchmarks for the Prevention and Management

 of Pain

* NICE (2010) Neuropathic Pain – The Pharmacological management of neuropathic pain in adults of

 non-specialist settings

* The British Pain Society and Royal College of General Practitioners (2008) A case of neuropathic pain
* The British Pain Society and Royal College of General Practitioners (2013 Implementing the British

 Pain Society Pain Patient Pathways and Preparing for the Commissioning Agenda (supporting

 document)

* Map of Medicine pathways
* BSR/BHPR guideline for disease-modifying anti-rheumatic drug (DMARD) therapy in consultation

 with the British Association of Dermatologists (2006).

* NICE DMARDs “Scenario: General Principles of managing DMARDs (July 2015)
* Scottish Intercollegiate Guidelines Network: “Management of early rheumatoid arthritis” (February

 2011).

* Patients are treated with privacy, dignity and respect at all times, all aspects of their service comply

 with the ten key components of ‘The Dignity Challenge.’ (Dept of Health, 2007);

* Patient information is treated confidentially by all staff and in strict accordance with Caldicott and

 Data Protection policies;

* The provider conforms to legislation prohibiting discrimination and the service should be open to all

 patient groups including housebound and hard to reach groups;

* The provider operates a complaints procedure in line with current guidelines. All complaints should

 be monitored, audited and appropriate action taken as required. The CCG is to be informed of any

 complaint made in relation to the service provided under this OOH;

* All relevant employees are trained in and comply with relevant infection control techniques and in

 accordance with best practice and local policies;

* The provider has a contingency plan for failure of or breakdown in the Service as part of its overall

 Business Continuity plans

* The DH MSK Services Framework (2006)
* NICE Guidance, Osteoarthritis; The Care & Management of Osteoarthritis in Adults. Feb 2008
* NICE Guidance, Rheumatoid Arthritis; The Management of Rheumatoid Arthritis in Adults. Feb 2009.

**4.2 Applicable Standards Set Out in Guidance and/or Issued by a Competent Body**

The following is not an exhaustive list; providers will be expected to adhere to all relevant guidelines:

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

**4.3 Applicable Local Standards**

Locally defined, general requirements for providers

|  |  |
| --- | --- |
| **Requirements** | **Applicable service category** |
| Provider is CQC registered with no conditions | All |
| Provider shares information with commissioners to support quality improvements (subject to IG rules). | All |
| Provider actively analyses and acts on feedback from patients and carers. | All |
| Hillingdon CCG Referrals Returns Policy (Appendix 3) | All |
| North West London Integrated Formulary | All |
| Hillingdon CCG Commissioning Intentions | All |
| NHS North West London Shaping a Healthier Future | All |
| Hillingdon CCG Implementation Business Case | All |
| Hillingdon Joint Health and Wellbeing Strategy | All |
| Practices have an open list | General Practice |

**5. Applicable Quality Requirements and CQUIN Goals**

**5.1 Applicable Quality Requirements**

* + Not applicable

**5.2 Applicable CQUIN Goals**

* Not applicable

**6. Programme Mobilisation**

* Once the contract has been awarded, a detailed mobilisation plan will be developed by the provider and agreed by the CCG. The plan will include key activities and milestones to provide reasonable assurance that the service will be mobilised on time.
* It is envisaged that in order to support the effective set up, mobilisation and implementation for the new service model, there will be resource with the knowledge, skills and experience to achieve and deliver the project objectives (part time for the entirety of the project). This will involve planning and monitoring the project from set up to implementation and include:
	+ Building, managing and sustaining effective partnership relations and communications with all project stakeholders
	+ Assessing and managing project risks
	+ Monitoring overall progress and use of resources, escalating actions as required;
	+ Reporting through appropriate management / governance processes
	+ Establishing baseline activity and monitoring the impact and benefits realization;
	+ Managing project administration; and
	+ Applying quality / change management principles and processes

During the service mobilisation period, the service Provider is expected to deliver the following milestones;

|  |  |
| --- | --- |
| **Description** | **Target Threshold** |
| Programme manager post recruited | Contract signature |
| Hub staff & SPA staff recruited (where required) | 1 month before service starts |
| System integration with SystmOne, CMC, Hillingdon Care Records (HCR) and other applicable systems | 1 month before service starts |
| Communication plan developed – including clear timeframes pre- and post-mobilisation to raise awareness and reinforce/ re-communicate messages | 2 weeks after contract signature |
| Implementation plan developed – including risk management log | 2 weeks after contract signature |

# 6. Service Development

* Service development will be a key agenda item during service review and contract performance meetings, with the service to suggest and take direction as to opportunities to test service developments over the course of the pilot. Some specific opportunities indicated at this time include the following:
	+ Self-referral
	+ Self-management, activation and social prescribing
	+ Assessment forms / questions / triaging protocols should undergo continuous development
	+ Model for stratifying patients, triaging and prioritising referrals based on clinical indicators
	+ Performance management and outcomes indicators as may be developed to enhance understanding of patient experience and service performance and quality.

**7. Performance Management**

* Performance monitoring will be critical during mobilisation and throughout the lifetime of the project and in order to demonstrate continuous quality improvement. The service Provider will supply the following information on a regular basis:
	+ Identify and track progress against defined objectives and outcomes
	+ Identify opportunities for improvement
	+ Compare performance against benchmarks
	+ Integration with other care services
* The following list encompasses the expected minimum requirements for quality reporting that will be supplied by the provider at agreed intervals during the project:
	+ Monthly activity reports – including KPIs relating to service utilisation and performance
	+ Significant events ( both positive and negative)
	+ Clinical audits findings and actions
	+ Adult safeguarding concerns
	+ Complaints, compliments and feedback from patients, families and carers
	+ Risk assessment, management and mitigation actions
	+ Monitoring, adoption and sharing best practice
	+ Evidence of MDT involvement and participation
	+ IT system integration
	+ Communications and engagement activities
	+ Provision of education monitoring and KPIs relating to staff competence.

# 8. Key Performance Indicators and Reporting Requirements (indicative for purposes of draft spec)

It is agreed that the MSK local KPI data must be reported by the provider to the Commissioner. Key Performance Indicators to be submitted within 10 calendar days of end of month. Breaches occur where KPI is off target for 2 reporting cycles (see Frequency).

**8.1 Local KPI’s**

|  |
| --- |
| **Local Quality Requirements** |
| **Outcome** | **Quality Requirement** | **Threshold** | **Method of Measurement** | **Consequence of Breach** | **Monthly , quarterly or Annual Application of Consequence** |
| 1. Individuals are empowered and supported to self-care | a. Patients with stable or long term MSK conditions receive a care plan that was developed in conjunction with them, including shared goals and clear prognosis for recovery | 95% | Monthly Activity and Performance Report | Penalty £300 for one of more breaches: Immediate application | Monthly |
| b. Patients state that they agree with the statement ‘I feel well informed and involved in my care’ | -85% of respondents-Return rate must exceed 25%  | -Patient Survey reported quarterly-Response rates reported quarterly | Remedial Action Plan | Quarterly |
| c. Patients state they agree with the statement ‘I feel well informed and involved in my care’ | -85%-Return rate must exceed 25% of total patients | -Patient Survey reported quarterly-Response rates reported quarterly | Remedial Action Plan | Quarterly |
| 2. Patients receive an accessible, convenient and responsive service | a. Patients to be offered first appointment within four weeks of receipt of referral by the service | 90% | Monthly activity and performance report | Penalty £300 for one of more breaches: Immediate application | Monthly |
| b. Urgent patients to be offered first appointment within two weeks of referral being received by the service | 95% | Monthly activity and performance report | Penalty £300 for one of more breaches: Immediate application | Monthly |
| c. Patients state that they agree with the statement ‘I was able to access an appointment at a time and location convenient to me’ | -75%-Return rate must exceed 25% of total patients  | Patient Survey reported quarterly | Remedial Action Plan | Monthly |
| 3. Satisfaction with the service is high | NHS friends and family test- patients state that they would recommend the service to their friends and family | -75%-Return rate must exceed 25% of total patients | Patient satisfaction Survey reported quarterly (quarterly and cumulative annually)Standard methodology for friends and family Test- http://www.england.nhs.uk/wpcontent/uploads/2014/07/fft/imp-guid-14.pdf | Penalty £500 for one of more breaches: quarterly reconciliation | Quarterly |
| 4. Information and communication between different parts of the health system is improved | a. Referrals to hospital services have full details of all available and relevant completed investigations, including diagnostic results, transferred with the referral | 100% | Monthly activity and performance report | Remedial action plan | Monthly |
| b. Care plans shared with the GP within days of initial assessment | 95% | Monthly activity and performance report | Remedial action plan | Monthly |
| c. Discharge letters, including ongoing care plans and recommendations shared with the GP 2 days post discharge from the Service | 95% | Monthly activity and performance report | Remedial action plan | Monthly |
| 5. Primary care knowledge regarding MSK conditions and MSK services is improved | a. Primary care professionals contacting the advice line service receive a response within 2 working days  | 95% | Monthly activity and performance report | Penalty £300 for one or more breaches: immediate application  | Monthly |
| b. Open education meetings or workshops for referrers will be conducted regularly | 100% | Meeting schedule, including at least 6 education sessions per year from all sub-specialties | Remedial action plan | Monthly |
| c. All patient discharge letters to be shared with the patients GP and referrer within 48hours | 98% | Monthly activity and performance report | Remedial action plan | Monthly |
| d. Patient care plans to be shared with the GP practice and referrer | 100% | Monthly activity and performance report | Penalty £300 for one or more breaches: immediate application | Monthly |
| 6. Services are safe and high quality | a. Patient contact initiated within 48hours of receipt of referral | 95% | Monthly activity and performance report | Penalty £300 for one or more breaches: immediate application | Monthly |
| b. Provider to undertake bi-annual clinical audit, but suitably qualified clinicians, analysing the appropriateness of patient management covering:-Patients seen, treated and discharged to primary care-Patients, seen treated and managed under a shared care agreement with primary care-Patients seen, assessed and referred to secondary careThe report must include details of achievement of the right care at the right time for patients, with a plan for future service improvements and rectification as identified by the audit | 100% | BI-annual report produces by provider at six monthly intervals. Audit to be conducted on statistically significant size of patients. | Remedial action plan  | 6 monthly |
| 7. Referrals to service | a. In scope MSK outpatient referrals for over 16 year olds (covering physiotherapy, MCATs, rheumatology, trauma & orthopaedics, pain and chronic pain management) channeled to the single point of access in accordance with the indicative activity plan  | Year 1: 60%Year 2: 70%Year 3: 80% | Monthly activity and performance report comparison against indicative monthly activity plan | GC9 | MonthlyApplication of KPI to commence 3 months from implementation date |
| b. Referrals accepted for triage via single point of access managed within community MSK service in accordance with the activity plan  | Year 1: 60%Year 2: 70%Year 3: 80% | Monthly activity and performance report comparison against indicative monthly activity plan | Penalty £500 for one or more breaches | ImmediateApplication of KPI to commence 3 months from implementation date |
| c. Monitoring quality of referrals to ensure diagnosis is appropriate i.e. Primary care pathway followed | 95% must meet criteria for referral  | Monthly activity and performance report | Remedial action plan | Monthly |
| 8. Referral management thresholds | a. Routine referrals triaged within 4 days | 95% | Monthly activity and performance report | Penalty £300 for one or more breaches | Immediate |
| b. Routine referrals seen within 2 weeks  | 95% | Monthly activity and performance report | Penalty £300 for one or more breaches | Immediate |
| c. Urgent referral triaged within 24 hours | 95% | Monthly activity and performance report | Penalty £300 for one or more breaches | Immediate |
| d. Urgent referrals seen within 5 days  | 95% | Monthly activity and performance report | Penalty £300 for one or more breaches | Immediate |
| e. Advice and guidance received within 24 hours or request | 95% | Monthly activity and performance report | Penalty £300 for one or more breaches | Immediate |
| f. Proportion of DNAs to service  | 10% | Monthly activity and performance report | Penalty £300 for one or more breaches | Monthly |
| g. Percentage of referrals received through eReferrals (previously Choose & Book) | 95% | Monthly activity and performance report | Penalty £300 for one or more breaches | Monthly |
| h. Hillingdon Referral Return Policy used  | 95% | Monthly activity and performance report | Remedial action plan | Monthly |
| 9. Diagnostic imaging referrals | a. Data quality improvement plan to be implemented to agree quality requirements to support best practice use of diagnostics that offers the NHS value for money | TBC in accordance with the quality improvement plan | TBC in accordance with the quality improvement plan | TBC in accordance with the quality improvement plan | TBC in accordance with the quality improvement plan |
| 10. Clinical outcomes from treatment | a. Patients report an improvement in their level of distress/emotional impact following treatment as identified using an accredited tool | -60% or more patients report improvement-No more than 15% of patients report a deterioration-Return rate must exceed 25% of total patients discharged | Monthly activity and performance report | Remedial action plan | Monthly |
| b. Audit is carried out quarterly to ensure that accredited outcome measures are being used pre and post treatment to analyse outcomes | -85% of records will evidence a review of outcome measures-Return rate must exceed 25% of total patients discharged | Quarterly audit report | Remedial action plan | Quarterly |
| c. An accredited tool will be use pre and post treatment to ascertain the level of functional improvement resulting from treatment | -85% of patients will experience a functional gain-Return rate must exceed 25% of total patients discharged | Monthly activity and performance report | Remedial action plan | Monthly |
| d. An accredited self-reported tool will be used to establish gains in patients ability to manage their condition post treatment | -85% report increase-Return rate must exceed 25% of total patients discharged | Monthly activity and performance report | Remedial action plan | Monthly |
| e . Reduction in the number of self-reported chronic pain-related sick days for patients of a working age on discharge compared to the 12 months prior to referral | -85% report increase-Return rate must exceed 25% of total patients discharged | Monthly activity and performance report | Remedial action plan | Monthly |
| f. Demonstrate improved medication prescribing trends across Hillingdon Borough for agreed medications | ? target | Monthly activity and performance report | Penalty £300 for one or more breaches | Monthly |
| g. Delivery against all agreed adult safeguarding protocols and procedures set out in service specification  | 100% | Monthly activity and performance report | Penalty £300 for one or more breaches | Monthly |
|  | h. Compliance with the required monitoring and reporting for patients on DMARDs | 100% | Monthly activity and performance report | Remedial action plan | Monthly |
| 11. Reduced demand on secondary care | a. Reduction in hospital outpatient appointments that result in immediate discharge | Less than 10% first appointment discharge ratio | Monthly activity and performance report | Penalty £300 for one or more breaches | Monthly |
| b. Increase in surgical conversion rates (i.e. first appointment to surgery) | 80% | Monthly activity and performance report | Penalty £300 for one or more breaches | Monthly |
| c. Demonstrate a reduction in inappropriate procedures to national average FA:FU and FA:Procedure | 90% within 6 months of contract commencement | Monthly activity and performance report | Penalty £300 for one or more breaches | Monthly |
| d. DNAs occurring in secondary care when referral originates from the Service  | 8% | Monthly activity and performance report | Penalty £300 for one or more breaches | Monthly |
| d. No SUI’s, complaints and ever events | 0% | Monthly activity and performance report | Penalty £300 for one or more breaches | Monthly |
| e. Evidence of DMARDs shared care agreement used for care of all appropriate patients | 100% | Quarterly audit report | Penalty £300 for one or more breaches | Monthly |
| f. Reduced waiting time for Rheumatology services |  |  |  |  |
| 12. Compliance with reporting | a. Submission of contract performance and Minimum Dataset within 10 days from month end. | 100% | Receipt date stamp on monthly activity and performance report | Penalty £300 for one or more breaches | Monthly |

**8.1 Local Reporting and Information Requirements (indicative for purposes of draft spec)**

|  | **Reporting Period** | **Format of Report** | **Timing and Method for delivery of Report** | **Application** |
| --- | --- | --- | --- | --- |
| **National Requirements Reported Centrally** |  |  |  |  |
| 1. As specified in the list of omnibus, secure electronic file transfer data collections and BAAS schedule of approved collections where mandated for and as applicable to the Provider and the Services
 | As set out in relevant Guidance | As set out in relevant Guidance | As set out in relevant Guidance | **All** |
| 1. Patient Reported Outcome Measures (PROMS)
 | As set out in relevant Guidance | As set out in relevant Guidance | As set out in relevant Guidance | **All** |
| * **National Requirements Reported Locally**
 |  |  |  |  |
| 1. Activity and Finance Report (note that, if appropriately designed, this report may also serve as the reconciliation account to be sent by the Provider by the First Reconciliation Date under SC36.28, or under SC36.31)
 | Monthly | [For local agreement] | By no later than the First Reconciliation Date for the month to which it relates, consistent with data submitted to SUS, where applicable | **All** |
| 1. Service Quality Performance Report, detailing performance against Operational Standards, National Quality Requirements, Local Quality Requirements, Never Events and the duty of candour, including, without limitation:
2. details of any thresholds that have been breached and any Never Events and breaches in respect of the duty of candour that have occurred;
3. details of all requirements satisfied;
4. details of, and reasons for, any failure to meet requirements;
5. the outcome of all Root Cause Analyses and audits performed pursuant to SC22 (*Venous Thromboembolism*);
6. report on performance against the HCAI Reduction Plan
 | Monthly | [For local agreement] | Within 15 Operational Days of the end of the month to which it relates. | **All****All****All****A****A** |
| 1. CQUIN Performance Report and details of progress towards satisfying any Quality Incentive Scheme Indicators, including details of all Quality Incentive Scheme Indicators satisfied or not satisfied
 | [For local agreement] | [For local agreement] | [For local agreement] | **All** |
| 1. NHS Safety Thermometer Report, detailing and analysing:
2. data collected in relation to each relevant NHS Safety Thermometer;
3. trends and progress;
4. actions to be taken to improve performance.
 | [Monthly, or as agreed locally] | [For local agreement], according to published NHS Safety Thermometer reporting routes | [For local agreement], according to published NHS Safety Thermometer reporting routes | **All (not AM, CS, D, 111, PT, U)** |
| 1. Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints
 | [For local agreement] | [For local agreement] | [For local agreement] | **All** |
| 1. Report against performance of Service Development and Improvement Plan (SDIP)
 | In accordance with relevant SDIP | In accordance with relevant SDIP | In accordance with relevant SDIP | **All** |
| 1. Cancer Registration dataset reporting (ISN): report on staging data in accordance with Guidance
 | As set out in relevant Guidance | As set out in relevant Guidance | As set out in relevant Guidance | **CR****R** |
| 1. Summary report of all incidents requiring reporting
 | Monthly | [For local agreement] | [For local agreement] | **All** |
| 1. Data Quality Improvement Plan: report of progress against milestones
 | In accordance with relevant DQIP | In accordance with relevant DQIP | In accordance with relevant DQIP | **All** |
| 1. Report and provide monthly data and detailed information relating to violence-related injury resulting in treatment being sought from Staff in A&E departments, urgent care and walk-in centres to the local community safety partnership and the relevant police force, in accordance with applicable Guidance (Information Sharing to Tackle Violence (ISTV)) Initial Standard Specification
* http://content.digital.nhs.uk/isce/publication/isb1594
 | Monthly | As set out in relevant Guidance | As set out in relevant Guidance | **A****A+E****U** |
| 1. Report on outcome of reviews and evaluations in relation to Staff numbers and skill mix in accordance with GC5.2(*Staff*)
 | * Six monthly (or more frequently if and as required by the Co-ordinating Commissioner from time to time)
 | [For local agreement] | [For local agreement] | **All** |
| 1. Report on compliance with the National Workforce Race Equality Standard and the National Workforce Disability Equality Standard \*\*
 | Annually | [For local agreement] | [For local agreement] | **All** |
| 1. Specific reports required by NHS England in relation to Specialised Services and other services directly commissioned by NHS England, as set out at
* <http://www.england.nhs.uk/nhs-standard-contract/ss-reporting>
* (where not otherwise required to be submitted as a national requirement reported centrally or locally)
 | As set out at <http://www.england.nhs.uk/nhs-standard-contract/ss-reporting> | As set out at <http://www.england.nhs.uk/nhs-standard-contract/ss-reporting> | As set out at <http://www.england.nhs.uk/nhs-standard-contract/ss-reporting> | **Specialised Services** |
| * **Local Requirements Reported Locally**
 |
| * **See indicative local reporting schedule below**
 |  |  |  |  |

**Indicative local reporting requirements (for purposes of draft specification)**

|  |  |  |
| --- | --- | --- |
|  | **Minimum dataset required** |  **Timing of Reporting** |
|  | Number of referrals received |  Monthly |
|  | Number of OPFAs and FUs |  Monthly |
|  | Number of CATS T&O FAs and FUs |  Monthly |
|  | Number of referrals from CATS converted to surgery |  Monthly |
|  | Number of discharges |  Monthly |
|  | Number of referrals triaged within 3 working days |  Monthly |
|  | Number of patients assessed within 6 weeks of referral |  Monthly |
|  | Number of discharge letters sent within 3 working days |  Monthly |
|  | Percentage of referrals returned: 1. For administrative reasons
2. For clinical reasons with a management plan
 |  Monthly |
|  | Number of referrals booked 1st appointment with ESP |  Monthly |
|  | Number of referrals booked 1st appointment with Consultant |  Monthly |
|  | Percentage of referrals booked 1st Appointment with Consultant |  Monthly |
|  | % of GP referrals that have complied with clinical pathways and minimum information requirements |  Monthly |
|  | % of GPS that referred via the eReferral system |  Monthly |
|  | % of patient questionnaires returned |  Quarterly |
|  | Number of patients identified as stable | Monthly |
|  | Number of patients briefed at first appointment | Monthly |
|  | Number of responses to patient satisfaction questionnaire and average score | Quarterly |
|  | Percentage of referral assessed outside lead time of 6 weeks  | Monthly |
|  | Number of Did Not Attend by new and FU (against total period appointments) | Monthly |
|  | Number of cancellations made by patient | Monthly |
|  | Number of educational sessions completed and attendance by practice | Quarterly |
|  | Number of patient Follow Ups that are not seen within their review period | Monthly |
|  | Total number of referrals received by practice  | Monthly |
|  | The number of referrals which have clinical compliance by practice. | Monthly |
|  | The number of referrals which have administrative compliance by practice | Monthly |
|  | Number of new appointments by treatment and diagnosis  | Monthly |
|  | Number of actual follow up appointments by diagnosis and treatment  | Monthly |
|  | Number on the active caseload by diagnosis and treatment | Monthly |
|  | Number of patients referred to secondary care providers, by provider and reason for onward referral | Monthly |
|  | Number of clinics held | Monthly |
|  | Number of Did Not Attend by new and FU (against total period appointments) | Monthly |
|  | Number of patients discharged by reason | Monthly |
|  | Number of cancellations made by patient | Monthly |
|  | Number of clinics cancelled by provider | Monthly |
|  | Number of unused slots | Monthly |
|  | Prescribing Report | Annual |

**Appendix A - Evidence Base**

**Orthopedics**

The Service Specification is also supported by the following evidence base and best practice guidelines:

* Department of Health (2006) ‘The Musculoskeletal Services Framework A joint Responsibility: Doing it Differently’

Key Points: Advocates that multidisciplinary interfaces are central to the Framework, acting as a one-stop shop for assessment, diagnosis, treatment or referral to other specialists.

* The ‘Getting it right first time’ (GIRFT) report. Professor Tim Briggs (2012).

Key Points: Considers the current state of England’s orthopaedic surgery provision, and links lack of GP MSK training with relatively high number of inappropriate referrals to orthopaedic services. Recommended establishing a dashboard for the MSK pathway in collaboration with community stakeholders.

* The Pennine MSK Partnership Ltd – provides an integrated MSK service for patients in Oldham.

Key Points: Demonstrated the effectiveness of clinicians working across care boundaries. Although this is a fully integrated pathway hub model, it was established as a triage service, successfully diverting significant levels of referrals away from hospital, by using a genuine multidisciplinary and holistic approach, which includes self-care and prevention, and engaging with GPs to provide them with advice and support on best practice

**Rheumatology**

The Service Specification is also supported by an extensive evidence base and best practice guidelines:

* Expert Opinions in Rheumatology: Issue 2 The PCR Society Guide to Commissioning Musculoskeletal Services (Sept 2011).

Key Points: States that community-based service encourages greater primary care involvement and is more convenient to patients if it reduces the time and cost of travelling for appointments and investigations, and can be designed to ensure that necessary expertise is available when required, with specialists holding joint clinics with GPs and other members of the primary care team.

* The State of Play in UK Rheumatology. Insights into service pressures and solutions BSR & BHPR (2015).

Key Points: Highlights the increasing number of rheumatology specific outpatient clinics being delivered in the community, some in GP practices, and often led by nurse practitioners. These clinics can be integrated with other complementary specialties, e.g. orthopaedics for fracture prevention and pain management.

* NICE Guidance: Specifying a service for people who need biologic drugs for the treatment of inflammatory disease in rheumatology, dermatology and gastroenterology. (2012).

Key Points: Discusses the key factors in commissioning biologic drugs for the treatment of inflammatory disease. These are a) ensuring all eligible patients have access to timely and cost-effective treatment, and b) developing high-quality cost-effective services for the safe administration and monitoring of biologic drugs.

* Rheumatology Commissioning Pathway Update, NHS Wiltshire CCG (Nov 2013)

Key Points: Wiltshire CCG commissioned the “Rheumatology Alliance” to conduct an online patient survey, telephone survey with GPs from Wiltshire and B & NES, and a workshop with patients, clinicians, stakeholders and public. Their report recommended working on developing patient self- management models, patient decision making and training of health professionals and support for GPs to use protocols for shared care.

* The NICE and BSR Guidelines on the Management of Rheumatoid Arthritis (2009).

Key Points: Advocates the use of annual review of RA patients, but cites a lack of evidence for its benefit, and uncertainty about the best approach to providing such a service. Highlights a need for coordination between primary and secondary care, to ensure there is no duplication of activities or omission because one party assumes the other is responsible for conducting an aspect of review.

* NICE Guidance [CG177], Osteoarthritis; The Care & Management of Osteoarthritis in Adults (Feb 2014).

**Pain Management**

The Service Specification is also supported by an extensive evidence base and best practice guidelines:

* Department of Health (2009) Improving Pain Management Services. Chief Medical Officers Annual Report 2008.

Key Points: Suggests that pain management services should be community based. Emphasises the importance of psycho-social elements and that specialist injections are provided by exception as part of a package of care.

* Dr Foster (2004) Adult Chronic Pain Management Services in Primary Care

Key Points: A review of pain management services which suggests that optimal pain management is provided outside of hospital. Promotes holistic approach to working with individuals and highlights a national lack of training for GPs.

* Foster G, et al (2009) Self – management education programmes by lay leaders for people with chronic conditions (Review). The Cochrane Library 2009, Issue 4.

Key Points: Systematic review of lay-led pain management programmes. Concludes that programmes lead to small but significant reductions in pain, disability and fatigue and improvements in in cognitive symptom management.

* Bodenheimer, T et al (2005) Helping patients manage their chronic conditions. California Health Care Foundation 2005.

Key Points: An extensive document showing that improvements to clinical outcomes that can be achieved through patients becoming activated and being supported to self-manage their condition.

* NHS Quality Improvement Scotland (2006) Management of chronic pain in adults - Best Practice Statement.

Key points: Promotes a bio-psychosocial approach to pain management, importance of individuals gaining good understanding of pain and maintaining functioning

* McQuary et al (1997). Systematic review of outpatient services for chronic pain control. Health Technology Assessment 1997; Vol. 1: No. 6

Key points: Strong evidence base for psychological approaches including Cogitative behaviour therapy, commentary on injections to be offered and not offered for chronic pain.

* The British Pain Society (2010) Opioids for persistent pain: Good Practice.

Key points: Promotes good practise around the prescribing of strong opioids for persistent pain. Raises awareness about limitations, long term affects and that these medications should not be used as a first line approach.

* Department of Health (2010) Improving the Health and Wellbeing of people with Long Term Conditions.
* Department of Health (2009) Supporting People with Long Term Conditions - Commissioning Personalised Care Planning A guide for commissioners
* Department of Health (2009) Your Health, Your Way - A guide to long term conditions and self-care. Information for Healthcare Professionals.
* Department of Health (2009) Self Care Support for Commissioners and Providers.
* Department of Health (2009) 18-week Commissioning Pathway for Chronic Pain.
* Department of Health (2010) Essence of Care 2010 Benchmarks for the Prevention and Management of Pain.
* NICE (2010) Neuropathic Pain – The Pharmacological management of neuropathic pain in adults of non-specialist settings.
* NICE (2009) Low back pain: early management of persistent non-specific low back pain. Full guideline. London (UK): May. 240 p. (Clinical guideline; no. 88).
* The British Pain Society and Royal College of General Practitioners (2008) A case of neuropathic pain.
* The British Pain Society and Royal College of General Practitioners (2013 Implementing the British Pain Society Pain Patient Pathways and Preparing for the Commissioning Agenda.
* Scottish Intercollegiate Guidelines Network – Management of Chronic Pain (Dec 2013).

This Service Specification also draws upon principles from other pain services currently commissioned in the UK, most notably:

* Telford & Wrekin and Shropshire Pain Management service.

Key Points: The service delivered quantifiable improvements in patient’s perception of their pain, showed evidence of patients taking effective self-control of their condition. The level of referrals to secondary care pain services, particularly for spinal injections, reduced significantly.

* Somerset Community-Based Self-Support Service for Adults with Persistent Pain.

Key Points: Service focuses on patients gaining good health literacy, becoming activated and being supported to self-manage. Strong message to GPs and patients that self-management support is the only intervention worth pursuing. Uses online pain management support system where users with chronic pain pass on their support to others with similar conditions in the community.

* Kent Community Health NHS Trust Pain Management Service.

Key Points: Service majors on keeping patients out of hospital, provides full assessment by multi-disciplinary team, uses Pain Self Efficacy Questionnaires, and pain education sessions. Has a single point of access into secondary care to minimise onward referrals.

And finally, this Service Specification references two specific tools that have been successfully used by both GPS and patients in many community based chronic pain services in the UK:

* The Keele University STarT back online Musculoskeletal Screening Tool

This is a simple and widely used screening tool which helps GPs take a more systematic approach to their decisions when faced with patients presenting with back pain, to risk stratify patients and match patients to the right treatment packages.

* The Royal College of Chiropractors “Measure Yourself Medical Outcome Profile (MYMOP) tool.

This tool measures patient-perceived changes in symptom severity, wellbeing and ability to undertake a key activity. These measures are combined to provide a ‘profile’ which is quantified before and at one or more intervals during a course of treatment.

# Appendix B - Pathways

The latest pathways are published on Hillingdon CCG extranet.

## Trauma and Orthopedics

TBC

## Persistent Pain

TBC

## Rheumatology

TBC

## DMARDS

Shared care protocol will be included when finalised in March 2017.

# Appendix C - Referred to documents

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| Referral Return Policy |  |
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**Appendix D – Clinical Pathways (TBC)**

**Appendix E – MSK Service referral form (TBC)**

**Appendix F – Other relevant local pathways, guidelines and protocols (TBC)**

1. [↑](#footnote-ref-1)
2. [↑](#footnote-ref-2)