SERVICE SPECIFICATION FOR

INTEGRATED MSK SERVICE

COMMERCIAL IN CONFIDENCE

Version Draft 1.1

June 2016

Service Specification Number	Add as required
Service	Integrated Musculoskeletal (MSK) Service for H&R CCG
Commissioner Lead	Hastings and Rother (H&R) CCG
Commissioning Partners	
Provider Lead	Include the name of the provider organisation that is the lead provider for this Service (xxx NHS Trust or similar)
Period	*1 July 2017 to 30 June 2022*
Date of Review	Either include a date when you wish to review the service part way through its contract period or as a minimum a review date prior to the expiry of the service period giving sufficient time to conduct the review and re-commission if necessary

Definitions	• Patient refers to Service User • Commissioner refers to CCG(s) and other commissioning partners where relevant • Provider refers to the organisation who will deliver the Service • Service refers to the Service in this specification

Version #	Author
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1. Population Needs

1.1 National and local context and evidence base

There are over 200 musculoskeletal conditions affecting millions of people nationally, including all forms of arthritis, back pain and osteoporosis. The ageing population will further increase the demand for treatment of age-related disorders such as osteoarthritis and osteoporosis. People with a need for MSK services require assessment, diagnostics and treatment which are delivered by a wide range of professional disciplines, predominantly orthopaedic surgeons, physiotherapists, other manual therapists, rheumatologists, pain management specialists, podiatrists and psychologists.

This service specification sets out the criteria for the different parts of an integrated Musculoskeletal (MSK) care pathway needed to meet and deliver high quality care to patients.

This Service Specification has been adapted from the MSK specification developed by members of NHS Eastbourne, Hailsham and Seaford CCG and High Weald Lewes Havens CCG and the Sussex Collaborative Delivery Team in consultation with stakeholders, including clinical staff working in MSK services, Public and Patients, other related services and Commissioners. This document builds on the (draft) Outline Service Specification, approved by the Governing Bodies in August 2013, which Commissioners have used in the competitive dialogue procurement process in which the clinical best practice solutions have been developed. It will provide clarity on whole system requirements for MSK services in a prescribed hub and spoke model.

This specification is based on extensive research, including systematic reviews, to support the effective management of patients with MSK conditions. National and local evidence has been reviewed and included where appropriate.

1.2 National evidence base

Information has been collated from national and professional bodies to inform the pathways of care for MSK patients. These include:

- National Institute for Health and Care Excellence (NICE) – guidelines and quality standards
- Musculoskeletal Service Framework (2006) Department of Health – promotes the redesign of services including multi-disciplinary services that act as a one-stop shop for assessment, diagnosis, treatment or referral to other services. It encouraged the sharing of care across organisational boundaries, improvement to integration and collaboration between primary and secondary care
- NHS Constitution – March 2013

- NHS Outcomes Framework 2013/14
- Francis Report – February 2013
- Guidance from professional and voluntary sector bodies such as British Pain Society, Arthritis UK, Arthritis and Musculoskeletal Alliance (ARMA), Chartered Society of Physiotherapists

1.3 Local evidence base

The majority of risk factors for MSK conditions are modifiable such as occupation, physical activity, diet and obesity. These risks can be addressed through primary prevention initiatives. However, with some risk factors related to disadvantaged social groups due to social deprivation there is a greater challenge to address the risk. MSK related health problems rise significantly with increasing social deprivation of all ages and is associated with a significant increase in global disability at ages 45 – 64 years.

Poor housing and type of employment can also influence the site of MSK conditions. Stress, depression and obesity are also associated with MSK conditions.

The Joint Strategic Needs Assessment (JSNA) for 2013 for H&R CCG summarises where there are concerns relating to population needs which include some of the issues highlighted.

The table below highlights the populations for H&R CCG (taken from the JSNA 2012 Needs profile):

CCG	Registered population
Hastings and Rother (H&R)	183,000
Total	**183,000**

1.4 H&R CCG

Hastings and Rother CCG has a registered population of 183,159 patients and is the second largest CCG in East Sussex. There are 48,140 patients in St Leonards, the largest locality, and 23,486 in West Hastings, the smallest locality.

The age profile of Hastings and Rother is similar to East Sussex. West Hastings has the highest percentage of patients aged 20-64, and the lowest percentage aged 65 and over (and 85 and over), of all East Sussex localities. Bexhill has the lowest percentage of patients aged 20-64, and the highest percentage aged 65 and over (and 85 and over), of all East Sussex localities.

Population projections show that over the next 6 years some age groups are projected to increase in size, whilst others will decrease. The net effect is that the population is estimated to increase by 2% by 2019 (3,100 more people). The largest estimated increase is in those aged 65 years and over, with a 9% increase by 2019

(3,900 more people aged 65 years and over).

2. Outcomes

2.1 NHS Outcomes Framework domains and indicators

The Commissioner utilises the NHS Outcomes domains in ensuring the commissioning of a high quality and patient focused service. The MSK Service must ensure that on-going monitoring is in place to ensure that the desired outcomes are met, including evidence of an entrenched culture of learning and sustainability.

The NHS Outcome domains are:

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

2.2 Locally defined outcomes – clinical and service

The Commissioner utilises locally defined clinical and service outcomes in ensuring the MSK service moves from a provider supply led model to a patient centred MSK service model. The MSK service must ensure on-going monitoring is in place to ensure that the desired clinical and service outcomes are met so that the quality of patient care and their experience of care is maximised at all times.

The MSK clinical and service outcomes:

- Improved patient experience and service quality for MSK patients and their carers through care organised around the patient through:
  - Shared Decision Making
  - Patient Choice
- Services delivered are sensitive to local health and service need, as defined in local outcome specifications including:
  - Access
  - Local population
- People are supported to maintain their independence, by providing preventative interventions thus reducing avoidable admissions, re-admissions and extended stays in acute hospitals. Facilitated by:

	➢ Shared Care Plans ➢ Supported self-management • Moving beyond traditional organisational and professional boundaries, so that front-line staff are supported to work effectively and flexibly to deliver seamless care ensuring: ➢ Right person, right time, right place ➢ Training and education • Delivering an organisational solution for MSK care demonstrates strong leadership, sound governance, resilience and the confidence of Commissioner and Provider partners • Demonstrating a credible approach to engaging patients and representative groups in design and delivery of services • Providing a sustainable financial model based on the principles below: ➢ aligning improved patient outcome with financial incentives ➢ Sharing financial gain and risk across the Commissioner/Provider system ➢ Delivering the recurrent financial balance in a sustainable way ➢ Creating the conditions for investment and delivering a return on investment • Communications which are integrated, timely and effective for Patients, Clinicians and Carers
2.3	**Choice** The Commissioner expects patient **choice** to be a priority at every stage of the MSK pathway through shared decision making and informed patient choice. Empowering patients to become active partners in their care through shared decision-making has proved to significantly impact on the choice for invasive interventions, reduce complaints and improve compliance. The expected approach is putting patients at the heart of the pathway and empowers them to make choices. Where the MDTs within the service agree that a patient needs onward listing for hospital based care, the Prime Provider must monitor the whole patient journey as well as the performance and outcomes of hospital providers to ensure a high quality of care throughout the system. In facilitating informed choice and promoting a high quality service, the Commissioner expects that patients will receive relevant hospital performance data for MSK.
3.	**Scope**
3.1	**Aims and objectives of the Service** This Service Specification reflects the scope, desired clinical outcomes and service requirements for a new Integrated MSK Service across H&R CCG. The Integrated MSK Service is referred to as the Service and the Clinical Commissioning Group (CCG) is referred to as the Commissioner. The Commissioner is clear that the Prime Contractor delivers the complete Integrated MSK Service.

The **aims** of the Service are to manage and co-ordinate consistent, timely, high quality, integrated and equitable MSK care to the defined population of 17 years old and over within the CCGs catchment by:

- Supporting self-care for patients with MSK conditions, which includes proactive healthcare self-management as well as referring patients to the range of health services available to them, e.g. health and wellbeing services, weight management services, local and national education and support;
- Continuing to develop clinical referral pathways agreed by the Commissioner utilising national best practice;
- Continuing to develop medication shared care arrangements with local GPs and the Commissioner for the management of MSK conditions;
- Up-skilling and supporting GPs and nurses in primary care so that patient care is provided in primary care whenever this is clinically appropriate;
- Triaging referrals against evidenced based clinical care pathways, to ensure that referrals are directed to the right professional;
- Providing rapid access to specialist advice and guidance, clinical assessment, diagnosis, treatment and rehabilitation;
- Delivering initial assessment and management within a co-located One-Stop model wherever possible;
- Delivering care through a hub and spoke model, including telephone as well as face to face consultations and use of web consultations where appropriate, supported self-care and through shared care for medications with patient's GP;
- Delivering holistic care, including the evidence based management of the psychological and emotional needs of patients and their carers to be integral to all pathways; risk assessments, care plans and self-management approaches;
- Management of treatment options to reflect patient's individual MSK and personal needs;
- Providing clinical leadership and case management where appropriate so that the patient's care is co-ordinated across the pathway;
- Implementing shared decision making so that patients, carers, healthcare managers and clinicians, social care managers and workers, third sector colleagues and the public work in equal partnership in making healthcare decisions;
- Working to eliminate unnecessary repetition of unsuccessful treatments or approaches and to reduce unnecessary interventions and hand offs between clinicians and services. This will ensure treatments are evidence based and are in line with the clinical pathways, including surgical thresholds, agreed with Commissioner;
- Ensuring only those patients who need and agree the services of hospital elective care by a sub-contracted provider or specialist tertiary care are referred onwards. Assessment of medical fitness within the Service prior to referral being completed where appropriate, co-ordinating and implementing a co-owned discharge plan with the patient, their carer and all relevant agencies;

- Acting as a single point of access for the same patients at the point they are discharged from hospital elective care provider or specialist tertiary care and co-ordinating and providing their rehabilitation and care, ensuring wherever possible that patients are supported and maintained in their own home;
- Sharing knowledge with clinical colleagues to ensure appropriate referral and that patients and carers receive 'joined up' and complementary care provision;
- Keeping the GP and the practice informed of all decisions relating to the patient's care in a timely manner;
- Keeping the Commissioner informed by providing timely high quality performance information, together with performance against the Key Performance Indicators (KPIs) and outcomes described in this Service Specification.

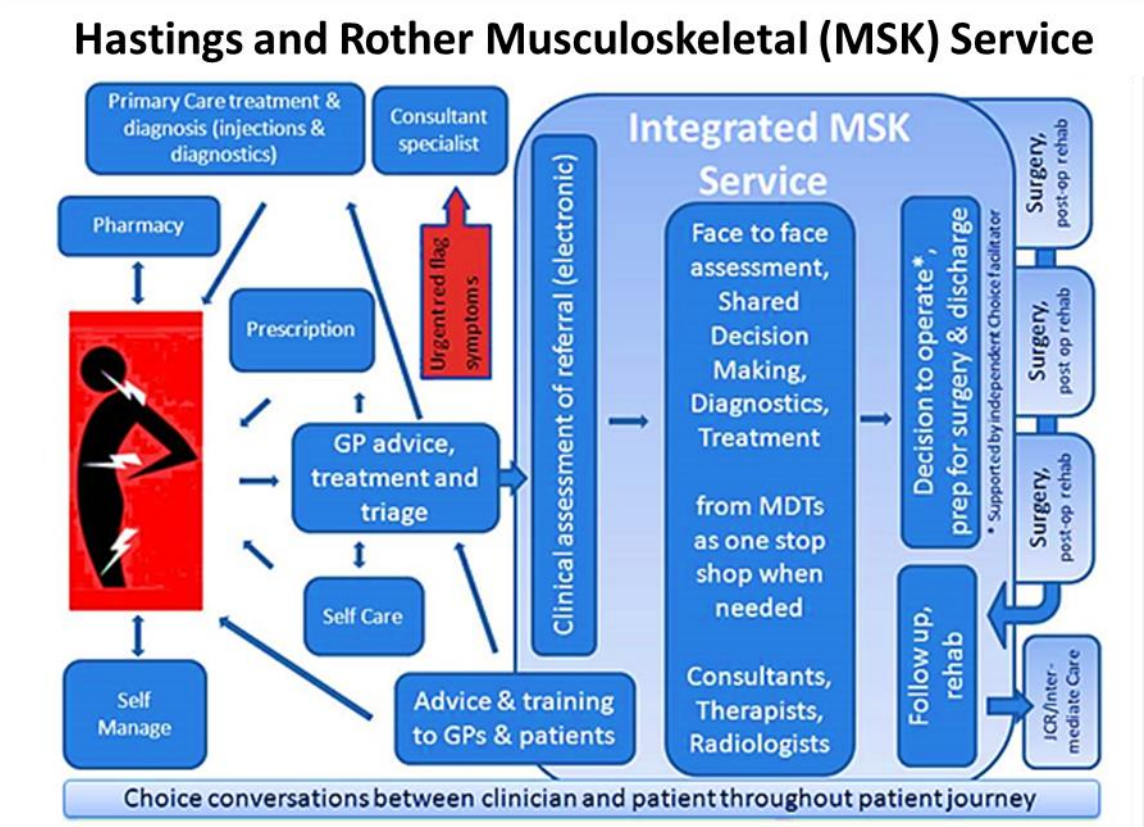
The Integrated MSK Service will **deliver**:

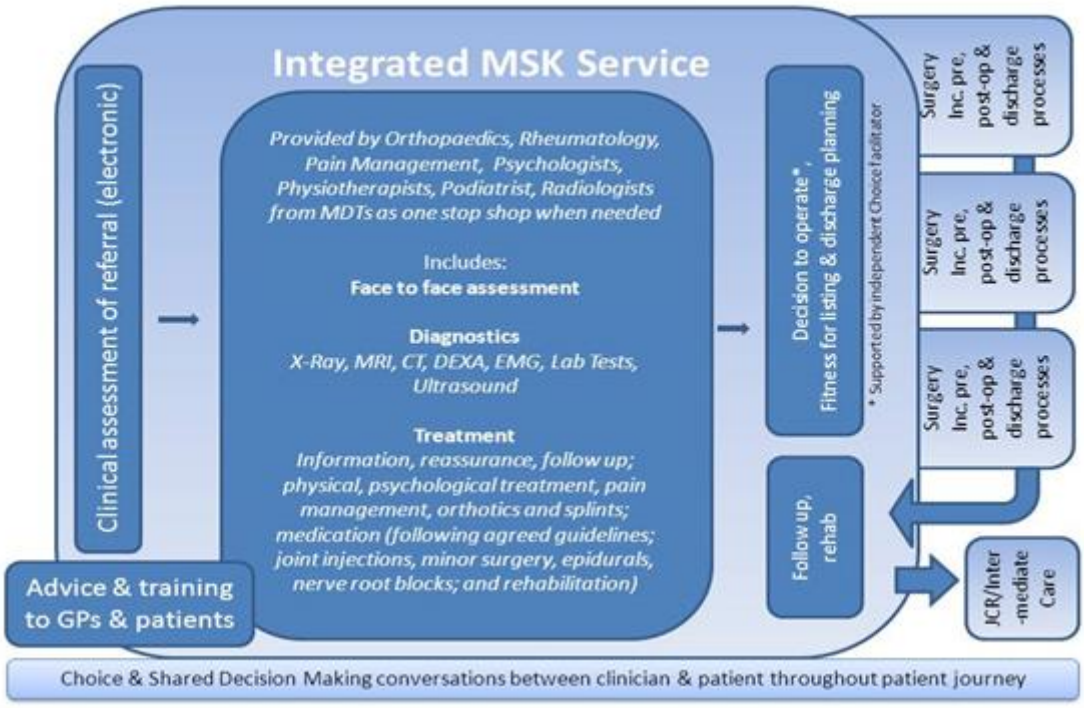
- Co-ordinated and integrated care across the MSK pathway as a whole (Orthopaedics, Rheumatology, MSK Pain and non-MSK Pain Management (excluding headaches but including cervicogenic pain), Physiotherapy (excluding neurological, cardiorespiratory, paediatric, amputee and falls prevention), and other evidence-based manual therapies, Osteoporosis and associated Podiatry and Orthotic services;
- Improved MSK health for a defined population by delivering tangible benefits and improved measurable clinical outcomes for patients and their carers;
- Sustainable multi-disciplinary community based MSK service model situated at the primary and secondary care interface that is delivered by a multi-disciplinary team inclusive of Consultants, GPs, Extended Scope Practitioners (ESPs), Nurse Specialists, Physiotherapists, other manual therapists, Occupational Therapists (OTs), Podiatrists and Psychological Therapists that are co-located and thus meet regularly for face-to-face discussions to agree treatment. This includes training and education for the current and future workforce as well as developing a successful Clinical Network within MSK Service;
- Reduction in waiting times;
- Strategies and processes to reduce incidence of non-attendance (DNAs);
- Equity of access to consistent levels of care;
- Improved knowledge and skills in primary care through training and education;
- Promotion of self-care through the development of a mutually agreed care and self-management plan, this includes flare management advice, a copy of which is held by the patient, GP and the service;
- Implementation of agreed shared care plans for medication between GP and patients.
- A protocol based approach that streams patients appropriately to ensure that patients see the right person in the right place first time;
- Identification of and reduction in unwarranted variation across the MSK pathway;
- Pathway efficiencies and the elimination of waste across the entire pathway;

	• Shared Decision Making, involving and informing patients and their carers about the options available to them along the MSK pathway including the use of agreed Patient Decision Aids (PDAs); • Choice at the point of onward referral to secondary care or more specialist services; • For patients on a surgical or invasive procedure pathway, fitness for procedures assessment, preliminarily consenting, direct listing (if clinically appropriate) and supporting early supported discharge planning; • A single point of access through which the patient's discharge and rehabilitation is coordinated; • Treatment and post-operative rehabilitation, education and advice; • For the more complex patients shared care arrangements between the patient, their GP and support of specialist teams; • Access to and delivery of diagnostics, to include Primary Care access to Diagnostics (MRI, pathology, X-ray, etc) to meet the requirements of One-stop Clinics as appropriate • Participation in, and support of, educational and training of medical students, junior doctors, nurses and other ancillary medical personnel
3.2	**The Service Model** The **Prime Contractor** will be responsible for planned MSK care and clinical delivery along with the financial and budgetary management, budgetary analysis and overall contract management of the system pathway. The CCG recognises their current outlier status in terms of expenditure on MSK and envisage a downward trajectory towards average spend against national benchmarks. The Prime Contractor will be required to deliver an **integrated system pathway** for MSK services that envisages the patient experiencing a seamless service across their entire journey. It places emphasis on prevention and self-care with the patient as an active agent rather than a passive recipient. Participation in, and support of, educational and training of medical students, junior doctors, nurses and other ancillary medical personnel. The community element of the service will delivered in accessible ambulatory hubs and spokes. The ambulatory hubs and spokes provide a **'one-stop' model** of MSK care, wherever possible. The hubs and spokes must have adequate parking facilities including those for the disabled, and accessibility for patient transport and public transport stops. Premises will be in locations that best meet local need and reduce health inequalities as well as improve equity of access. The **hub** will provide a range of services that meets the needs of patients with more complex health requirements. The hub will need to be supported by diagnostics that support the One-Stop model. The hub will consist of: • Access to diagnostics including phlebotomy, X-Ray, DXA, Ultrasound, MRI (or

	ability to have a mobile scanner on premises if necessary); • Multiple clinic rooms for multi-disciplinary teams – Consultants, GPs, nurses, ESPs, etc; • Fully equipped and functioning rooms delivering MSK assessment and therapies; • Minor surgery clinic rooms which meet national requirements; • Capacity to host MSK patient groups, community support groups and voluntary sector support; • Administration support; • IT infrastructure to support clinical practice, e.g. access to imaging and diagnostic results • Facility for image guided injections • Facilities for teaching and training • Facilities and provision of day case procedures like Carpal Tunnel decompression, Trigger finger, excision, excision of ganglion, cysts. **Spokes** will provide assessment and treatment, be able to accommodate high volumes and offer a range of services. The minimum requirements for the spoke are that it consists of: • Clinic rooms for patient assessment and treatment; • Ability to host Consultants, nurses, GPSIs as required; • Access to some diagnostics as appropriate; • Manual therapies; • IT infrastructure to support clinical practice e.g. access to imaging and diagnostic results

3.3 Service Description and Care Pathways





The Integrated MSK Service illustrated above ensures patients move seamlessly within the pathway as required. This allows patients to move between specialists within the MSK Service as clinically appropriate. For example, if a patient seeing a member of the

Pain Management Team was thought to have a Rheumatological condition then that patient would seamlessly transfer over to a member of the Rheumatology team for further assessment.

Self-management with Primary Care Support

The use of **Self-management** must be promoted and delivered by the Service for patients through education and agreed supported self-management plans. Primary care clinicians should be supported to do what a 'good GP should do', resulting in patients being given appropriate information and management early in their journey. **Primary Care** interventions may include the provision of splints, joint injections in primary care by Commissioner's agreement and up-skilling of GPs as clinically appropriate. The MSK Service will work closely with the front end of the pathway by providing support and advice. By providing educational, meaningful and regular feedback to referring clinicians, the quality of the referrals into the Service should continually improve. The feedback to Primary Care clinicians must include information about referral rates, and the quality of the referrals. In addition, generic training and education is delivered in accessible formats for all primary care clinicians.

A variety of tools and techniques that can support **patient information** and increase their knowledge should be utilised to ensure that patients understand their conditions, what the treatment plan may be and that they are involved along the pathway of care. This is essential because with MSK conditions the recovery of the patient or maintenance of their condition is dependent on the actions of the patient e.g. undertaking specific exercises between appointments.

Following a period of MSK treatment, a patient will be able to self-refer back via a telephone consultation initially (or any other appropriate method as agreed with the patient) with the Service if the same condition recurs within a six month period.

Self-management will be promoted and the importance of compliance with treatment regimens will be emphasised. The Service works towards a safe discharge after effective care where clinically appropriate. The exception will be certain MSK conditions, such as Rheumatological conditions, where on-going care provided by the MSK Service is clinically appropriate.

On **discharge** from the Service, a **self-management plan** is agreed with the patients. This will describe the patient's self-care action plan and a copy will be held by the patient, the GP, as well as the Service. It will be inclusive of maintenance, exercise advice and flare management advice. Motivational techniques will be utilised ensuring patient centred care and collaborative development of the self-management plan. Employed Clinical staff will receive motivational technique training.

The Provider will develop **an electronic information hub** for patients, carers and healthcare professionals that will provide educational tools, such as information leaflets, videos, exercise information, and information about alternative services, such as Health and Wellbeing Services, smoking cessation and exercise referral schemes.

These should be patient friendly, written in plain language with availability of translation services when required

Community-based Integrated MSK Service

Referral process

In line with the Health Secretary's aim for a paperless NHS by 2018, the aim is for all MSK referrals to be sent electronically. The Commissioner recognises that paper referral via post of fax may be required as Business Continuity and the Prime Provider will need to ensure provisions are made for referral should there be a failure of one or more IT systems.

An **electronic referral process** will also facilitate Choose and Book or equivalent service and the audit of activity. In addition, electronic referrals will allow triage clinicians to evaluate patients' needs and ensure they see the **right person at the right time in the right place**.

The Integrated MSK Service provides a **single point of access** for GPs and other Health Professionals into the MSK service and **choice** of secondary care provider will be offered in the hub if specialist hospital care is required. Clinicians will refer directly to the service.

The service has to be able to receive, triage and offer appointments to patients for a period in advance of the start of clinical services. This is to ensure that clinical capacity is in use from service commencement.

Patient Access

The Service will be accessible to all residents registered with a GP practice which is a member of H&R CCG.

The Service will also need to make appropriate provision for local patients who are Travellers or have no fixed address.

The Service is available to all patients of 17 years or over irrespective of race, religious beliefs, disability, ethnicity or sexual orientation.

The availability of the Service should be flexible to reflect the needs of the working and elderly populations. It is the aspiration of the Commissioner that this will eventually be achieved through extending hours of service and 7-day working.

Clinical Care Pathways

All referrals, irrespective of their source, will be treated equally, receiving treatment within 18 weeks of referral.

Clinical Care Pathways describe the expected assessment; work up and management of the patient; the threshold for referral; and the referral destination. It is recognised that pathways will need to be developed, amended and agreed by Commissioner in

the light of the new Service. The Clinical Care Pathways are evidence based and describe the clinical care appropriate for the MSK service levels of, self-management, primary care support, ambulatory care support and hospital care. The Service will triage all referrals against these pathways and return to the referring clinician any referral that has not followed the pathways or where there is insufficient information on which to complete the triage process

There is recognition that not every individual patient fits into a pathway so they should be used as guidance and not as absolute protocols.

The Service will work with the Commissioner to develop standardised referral formats where the Commissioner thinks appropriate.

Rheumatology
The Integrated MSK Service will work with the Commissioner to develop agreed **shared care arrangements for Rheumatology drugs** as clinically appropriate and in line with agreed clinical pathways and best practice.

Shared Decision Making
Shared Decision Making (SDM) will form a key component that underpins the service. SDM will be utilised by the service signposting patients to Patient Decision aids and online tools such as for knee and hip MSK conditions, to supply information and advice to patients and guide them through decision making. SDM refers to the principle of clinicians and patients working in partnership to agree the preferred treatment from a range of options appropriate to the patient's condition(s). There is a rapidly developing national programme to support SDM (including a variety of tools to support SDM and relevant training opportunities). The service must fully embrace SDM approach and implement across the Service. There is also a local programme of training and development of patient decision aids.

Using a SDM outcome tools will enable the Commissioner and the Service to fully evaluate the impact of SDM.

Integrated MSK functions
To ensure the delivery of all the benefits of an Integrated MSK Service it will be necessary to provide the following functions:

- **Primary Care Advice and Guidance**: GPs and other healthcare professionals will have access to advice and guidance services by telephone or email to support in the diagnosis and the on-going management of the patient in primary care.

- **Triage Gateway**: Electronic triage will be carried out by appropriately trained and qualified clinicians according to agreed speciality or condition specific protocols that result in the patient being directed to the correct clinical team and the correct clinician within that team. This will be achieved within 1 working day depending on potential condition and relevant national standards. Triage must result in the

patient being directed to the right person, right place, and first time. Triage will prioritise the referral with outcomes to include:

- Re-directing patient to their GP with advice for further work up and management
- Re-directing referrals to a range of other primary services
- Directing patients for assessment and/or diagnostics within the hub multi-disciplinary team, including those who appear clinically appropriate for hospital based MSK care
- Real time feedback to or to gain further information from referring clinician
- Capturing inappropriate referrals and reporting these to the Commissioner (on a monthly basis) so that remedial action can be taken to resolve issues through education and support
- Booking Appointments: The service will contact the patient to offer and agree with the patient a time, date and place for their appointment and discuss any special needs that they have

- **'One-stop' Specialist Ambulatory Hubs:**
  - Multi-disciplinary Team Working: The co-located MSK clinicians will actively work within the Multi-disciplinary Team seeing patients and supporting genuine multi-disciplinary working
  - Medical Consultants will be co-located with other MDT members within the Ambulatory Hubs to maximise multi-disciplinary clinical practice and support the members of the team and facilitate listing for procedures
  - The Service provides regular face to face meetings as an MDT occur to agree treatment and ensure best practice pathways of care
  - Clinical Assessment Function: This will be provided by appropriately skilled and experienced clinicians and will include:
    - One-stop clinical assessment, diagnostics, shared decision making, advice and support. Appointments must be long enough to allow the patient time to ask questions and receive responses. It should be staffed by clinicians who have read the referral and any other correspondence before the appointment.
    - Screens for remedial conditions if they are MSK related and refers patients to other specialities with appropriately skilled and experienced clinicians without delay and if appropriate within the MSK Service. Should a clinical condition be identified and not related to the MSK service the patients must be referred back to the GP, or alternatively referred onto the agreed referral pathway.
    - Provides a route so that, where appropriate, patients will be assessed at home.

- **Diagnostics:** The term 'diagnostics' refers to any investigative tests or imaging carried out to aid and support the identification and extent of the patient's condition. A range of diagnostic tests and imaging of varying complexity will be

required to support clinical management and care with the service. Infrastructure and contractual arrangements are in place to deliver access to the diagnostics, radiologist reporting of images and clinician access to the image, report and the results. Diagnostics will include (but not exclusively): X-Ray; Access to pathology, biochemistry, microbiology, haematology and immunology; MSK ultrasound; MRI; DXA.

The Service must be able to access more complex diagnostics including CT, Nerve Conduction Studies/Electromyogram (EMG), and nuclear medicine.

The key principles underpinning the provision of diagnostics within the Service include:

- Maximised use of innovations and technology i.e. process, pathways, remote reporting, open architecture MRI scanners and telemedicine
- Utilisation of information from any diagnostics test already undertaken during the patient pathway to avoid repetition and duplicated cost, and provision of the results of any diagnostic test to any subsequent provider if referred on
- Ease of access for the patient, including supported Primary Care access to diagnostics.
- Provision of one-stop access to diagnostic services to inform the diagnosis and management plan with an expectation of same day reporting
- Prompt and clear communication of test results to patients, preferably by the clinician who requested the test
- Use of diagnostics and imaging services will be in line with national best practice
- Access to all diagnostics via the appropriate IT systems, for example, PACS and other NHS information systems as required, in order to allow electronic sharing of images and reports both within and outside of the Hub as appropriate
- The Service will ensure electronic forwarding of images and reports to secondary care in the event of a patient being referred onwards.
- The Service will, where appropriate, receive previously completed imaging
- Full co-ordination of any diagnostics delivered (or subcontracted from a third party) with the community service.

Treatment function

The Integrated MSK Service will provide a number of evidence based interventions in appropriately licenced and contracted community, day case and inpatient facilities:

- Provides treatment, e.g. injections, appliances/orthotics, access to physiotherapy, MSK occupational therapy, podiatry and medication advice;
- Provides rehabilitation programmes and services, e.g. Functional Restoration Programmes (FRP), Osteoarthritis Knee Group classes, Hydrotherapy. These should include evidence based group sessions which promote shared decision

making and supported self-care;

- Provides Psychological Therapy for patients with persistent pain both in an individual and group setting, i.e. pain management programme;
- Provides a full Multi-disciplinary Pain Management Service offering medication, assessment and treatments appropriate for that individual patient;
- Provides the full range of Multi-disciplinary Rheumatology Services offering assessment, treatment and, if clinically appropriate, on-going follow up and medication under agreed shared care arrangements with the GP, this includes oral DMARDs. Injectable DMARDs will be administered on-site (intravenous formulations) or delivered using a homecare service as appropriate and safe;
- Provides a Consultant delivered Multi-disciplinary Orthopaedic Service offering assessment and treatment;
- Fully manages the sequence of care, including diagnostic work up and direct listing for surgical procedures as appropriate;
- Minor Procedures and Surgical Interventions: provided by the Service will be carried out in the appropriate environments which meet national standards. Treatment may also consist of a variety of therapies and other non-surgical interventions. There must be an evidence base for all treatments offered within the integrated community service. These should also comply with all relevant NICE guidance and other clinical best practice and thresholds as agreed by the Commissioner;
- For patients referred on for elective consultant-led hospital based care interventions the Service will complete the fitness for surgery procedure work up and initial informed consent. It must offer **choice** of secondary care provider and capture the outcome of **choice** discussions, and forward the referral to the Hospital Provider of the patient's **choice** and liaise effectively with this Provider to ensure a smooth patient pathway; develop an agreed discharge plan and organise post-operative support in the form of intermediate care beds with external providers as clinically appropriate; act as a single point of referral post operatively back into the Service for rehabilitation as required and discharge

This Service Specification lists a range of treatments identified by national guidance as being appropriate for community theatre setting. This is not an exhaustive list and is intended as an indication of possible treatments appropriate for the community service:

- Intra-articular injections and soft tissue injections;
- Image Guided Caudal Epidurals/facet joint injections and radiofrequency denervation if successful/nerve root blocks/SIJ injections;
- Manipulation;
- Aspiration of knee/joints;
- Podiatry

Pathways:
In order to ensure that patients experience a fast, convenient and high quality service

across the MSK system the MSK service will be underpinned by "right care, right place right time" pathways that:

- build on best practice with engagement of all providers and stakeholders across the pathways;
- standardise best practice across all sub-contracted providers with shared pathways and single patient records;
- rapidly identify and deliver appropriate interventions (including self-management) in the right setting, using the most cost effective healthcare professionals;
- offer direct access to diagnostics (e.g. MRI, ultrasound and plain film X-ray) with incentives for appropriate investigation prior to secondary referral;
- offer robust self-management plans with appropriate levels of patient education and information;
- eliminate unnecessary attendances in secondary care and surgery;
- where appropriate, allocate specialist nurses to help co-ordinate care for patients; and
- implement best practice ratios for new to follow-up out-patient appointments where appropriate, increase procedures undertaken in an outpatient setting and maximise day case surgery.

Orthopaedic Pathway:
For patients that have been referred on for integrated MSK procedures, the Provider will fully manage the sequence of care, including diagnostic work up and direct listing for procedures as appropriate within a Multi-disciplinary MSK Team, including Consultants. The Service will complete the fitness for surgery work up and initial informed consent. Discharge planning for the individual patient will also take place.

Increased health gain as assessed by patients for elective procedures for appropriate condition specific pathways.

The range of treatments and procedures that are commissioned by NHS England as Specialist Commissioning, rather than being commissioned by Clinical Commissioning Groups, is not currently included in this Service.

Rheumatology Pathway
The Integrated MSK Service will bring together all ambulatory Rheumatological Services, offering a multi-disciplinary approach for patients inclusive of Consultants, GPs, Nurse Specialists, Occupational Therapy and Physiotherapists and other evidence-based manual therapists. The services will assess, diagnose and manage a wide range of Rheumatological conditions. These include Inflammatory Arthritis, Polymyalgia Rheumatica (PMR), Autoimmune Rheumatic Disease, Osteoporosis, and other conditions such as Fibromyalgia and Hypermobility. All current Rheumatology patients within the CCG areas as well as all new patients with Rheumatological conditions will be referred into the Service.

The Rheumatology function in the MSK Service will offer people access in a variety of patient centred methods, such as computer access, face to face or telephone as required clinically, face to face clinical to:

- a multi-disciplinary team for periodic assessments of the effects of their disease on their lives (such as pain, fatigue, everyday activities, mobility, ability to work or take part in social or leisure activities, quality of life, mood, impact on sexual relationships) and help to manage the condition, including educational and self-management activities;
- a named member of the multi-disciplinary team (for example, the specialist nurse) who is responsible for coordinating their care and Shared Decision Making;
- psychological interventions (for example, relaxation skills training and other relevant psychological therapies);
- specialist occupational therapy, with periodic review;
- specialist physiotherapy, with periodic review;
- Podiatrist for assessment and periodic review;
- Orthotics.

Those patients that do not require on-going follow up by the Rheumatology MDT, are discharged to GPs with a co-produced self-management plan describing the patient's on-going self-management and flare management that is held by the patient and GP.

NHS England commissioned Specialist Rheumatology falls outside the scope of this specification.

The MSK service will follow current and updated specific NICE interventional procedure guidance are to be taken into account when managing Rheumatology patients. There are regular updates on standards and guidelines which the Service and clinicians should be aware of and ensure in agreement with the Commissioner implement guidance. Key links are:

http://www.rheumatology.org.uk/resources/policy/nice_update.aspx
http://www.rheumatology.org.uk/bhpr/clinical/guidelines.aspx

The Service should refer to and meet the quality standards which have been agreed by the British Society for Rheumatology for Spondyloarthritis and Rheumatoid arthritis.

Rheumatology Transitional Care

In line with the national Specialised Services Specifications for Paediatric and Adult Rheumatology, the specialised paediatric rheumatology teams will provide transitional care to facilitate transfer and on-going care in adult rheumatology. Transitional care planning will involve the MSK Service under a shared care arrangement Royal College of Paediatrics and Child Health (RCPCH) (RCPCH 'Bringing networks to life' 2012). The Specialist Paediatric MDT team will have close links with

the Rheumatology team within the MSK Service for transitional care.

Pain Pathway

The Integrated MSK Service will provide an ambulatory Pain Management multi-disciplinary service, including consultant medical staff. The following specific elements of the care pathway will be provided:

- To assess, diagnose and treat patients with acute and chronic MSK pain, and non-MSK Pain (excluding non cervicogenic headaches but including cervicogenic pain) that has not responded to expected primary care treatment;
- Reducing the number of patients dependent on repeated injections;
- ESPs and Physiotherapists to provide a Functional Restoration Programme that takes both an exercise, educational and Psychological therapeutic approach to MSK persistent pain;
- A wide range of skills and knowledge of the bio-psychosocial model of pain management and appropriate Psychological therapy modalities;
- Development of self-management and access to telephone support and shared decision making and will discharge patients with a clear self-management plan that is developed with the patient;
- The following invasive diagnostic and treatment interventions will be provided within the MSK Service where appropriate: Facet joint injections and subsequent radiofrequency denervation if successful; Sacroiliac joint injections; Caudal epidurals; Transforaminal epidurals; Nerve blocks; Intravenous regional blocks; Trigger point injections;
- This list is not exhaustive.

Evidence based psychological interventions either in clinic or more substantively in a Functional Restoration Programme or Pain Management Programme dependant on patient need will be delivered by Pain Management Psychology as well as a wider MDT approach, in line with the British Pain Society guidelines.

As part of the Integrated MSK Service, the Pain Management Team may also utilise Medication, Acupuncture, Psychotherapy, Physiotherapy, and Hydrotherapy.

The Physiotherapy Pathway

The physiotherapy clinicians must implement a well-organised multi-disciplinary and evidence-based approach to patient care. Use will be made of validated assessment tools and evidence based approaches to management such as Osteoarthritis knee classes and the Functional Restoration programme both of which deliver an educational and exercise based programme with supported self-management, shared decision making and CBT intrinsic to the courses.

If a patient is not progressing they should be referred seamlessly within the MSK Service to the most appropriate clinician.

The Physiotherapy Service will:

- Provide direct access into physiotherapy;
- Develop a service to meet best practice. This service must interface seamlessly with referring GPs or other health professionals, the wider community MSK service, local voluntary sector support groups to ensure direct and unencumbered patient pathways in the event that the patient is referred onwards;
- Improve the quality of services and clinical outcomes, reduce waiting times and improve access for patients;
- Undertake telephone triage or consultation or signposting to other services. Telephone follow up will occur where clinically appropriate;
- Provide packages of care that ensure patients progress swiftly along an evidenced based pathway which include individual and group settings;
- Improve and demonstrate clinical outcomes;
- Develop care plans. All patients seen by the Service will have a self-management plan that has been agreed with the patient on discharge. A copy of this will also be sent to their GP;
- Provide fast access to a physiotherapist in the event of recurrence of the same condition for reassessment, up to six months following discharge from the service (or a time period agreed between the physiotherapist and the patient).

MSK Podiatry Pathway

The primary purpose of the Service is to maintain foot health. It is primarily concerned with the assessment, diagnosis and treatment of associated conditions affecting the foot and lower limb.

The Service should deliver an innovative, consistently high quality professional therapeutic input and comprehensive foot health service to reflect the needs of the local community.

Podiatrists should work in partnership with other MDT members in the care of patients, thereby preventing premature or inappropriate admission to hospital or long-term residential care and thus maintaining personal independence and enhancing quality of life. The Service should provide:

- General service to high risk MSK patients based on medical and podiatric need;
- Nail surgery for “in-growing” toe nails;
- MSK service for assessment of foot function and gait and supply of orthoses for patients seen within Podiatry.
- Conservative management of common condition like Hallux valgus, rigidus, hammer toe, plantar fasciitis, Mortons neuroma, Metatarsalgia

The Podiatry Service will work within the professional standards and guidelines and monitor quality standards closely. Audit of practice and records to assure quality in those areas and outcome measuring when nationally developed will need to be used.

The Podiatry service will work as an integral part of the MSK Service providing time limited care planning and treatment, with long term care being the exception.

In MSK podiatry the service will provide assessment, access to investigations, physical therapy, injection therapy and a wide range of braces and supports as well as functional orthoses, and in some cases prescription of footwear.

Podiatric Surgery: is the surgical treatment of the foot and its associated structures. It is carried out by a Podiatric Surgeon, usually as a day case procedure and often under local anaesthetic. The types of foot deformity dealt with are for example Hallux valgus, hammer toe, neuroma and osteoarthritis. It is included within the Service.

Manual Therapy
It is expected that the Service will provide access to other evidence-based manual therapy modalities, in response to patient choice.

MSK Orthotic service is to:

- Provide suitable insoles and orthoses for all those with a permanent MSK condition that impairs their functionality;
- Provide a comprehensive service that includes consideration of comfort, posture, function, pressure relief and cosmesis;
- Fit, maintain and repair orthotics equipment in a responsive, rapid and effective manner;
- Respond to changing medical and social needs of orthotics users with provision of different orthoses when necessary;
- Provide the one-stop approach to assessment and treatment as clinically appropriate and then discharge with self-management plan as part of the Integrated MSK Service;
- To ensure patients know when and how to re-access the Service. Develop innovative approach to ensure users do contact at an earlier stage to support user independence;
- Ensure the frequency of the reviews and self- management should be consistent with the prognosis.

Equipment:

- All equipment purchased meets the requirements of the Medical Devices Directive;
- There is feedback on supplier performance to the NHS Purchasing and Supplies Agency;
- There is feedback on adverse incidents to the Medical Devices Agency.

Osteoporosis Pathway

	This pathway is delivered by the MDT, including the Rheumatologist, and including the Specialist Nurses with access to OT and Physiotherapy Services inclusive of Hydrotherapy within the MSK Service. As part of the integrated MSK one-stop interdisciplinary clinic it consists of: • A consultant with a special interest in metabolic bone disease, including fragility fracture prevention; • An experienced clinical nurse specialist in osteoporosis to provide education and when required, to administer any parenteral treatment; • A senior physiotherapy specialist with a particular interest in the prevention of fragility fracture and the management of vertebral crush fractures. There will be access to diagnostics, including Pathology, X-ray, MRI and DXA scans. Key elements of the Pathway will be shared decision making, empowering and engaging patients to self-manage, particularly with regards to lifestyle change, inclusive of stopping smoking, reducing alcohol intake, increasing exercise as well as compliance with medication. The MSK Service will discharge each patient with a completed personalised fracture prevention plan which supports lifestyle modification, where appropriate referral to the separately commissioned Falls Prevention Service and recommendation for bone protective medication. The service will follow and update the in light of best practice and NICE guidelines. For example: http://pathways.nice.org.uk/pathways/osteoporosis. The Service ensures that it delivers an Osteoporosis Education Programme, including patient support groups, or signposts individuals to available resources.
3.4	**Medicines Management** **Statutory and Regulatory Guidance** The Service must operate within the legislative framework for medicines in the UK, i.e. the Medicines Act 1968, the Misuse of Drugs Act 1971 and all associated regulations. All medicines will be maintained, stored and disposed of in accordance with the Misuse of Drugs (Safe Custody) Regulations, as well as best practice. NICE Technology Appraisal guidance (TA) must be implemented within 90 days of being formally issued. Provider(s) are expected to engage with the relevant Area Prescribing Committee (APC) when a TA is issued to inform them of their intention to implement, and to complete the relevant paperwork to enable the APC to make the relevant amendment to the medicines formulary.

Prescribing and Recommending of Medicines
The Service will ensure that the prescribing and recommending of medicines is in accordance with the East Sussex Health Economy Formulary for H&R CCG. Where bases and clinicians carry stock medicines, these should also comply with the formularies. The formularies are regularly updated by the Commissioner.

For National Tariff high cost drugs the MSK service will work in accordance with the CCGs' annual commissioning intentions for high cost and specialist drugs. The MSK Service may also apply to have medicines added to the formularies or have a medicine's entry amended. This should be done by making an application to the relevant APC. Only when the medicines formulary has been amended should the new medicine be prescribed or recommended by the Service.

The MSK Service will be expected to contribute to the development of and comply with any other medication policies and treatment pathways that are in place for medicines associated with the MSK Service. This includes the use of a specified National Tariff high cost drug authorisation procedure and relevant shared care documentation.

The MSK Service will be expected to follow the management of infection in primary care guidelines, where this has been amended to take into account any local resistance patterns.

Where homecare companies are contracted to deliver medicines, the MSK service will ensure companies with a track record of good quality and value for money services are used. Any new arrangements for homecare agreements entered into by the Service will be submitted and approved by the Commissioner before they are commenced.

Process for Supplying Medication to Patients
The Service will purchase stock medication to treat patients during the consultation and provide non-acute drugs by FP10 prescription (or non-NHS prescription if prescribing a National Tariff high cost drug).

The following categories must be initiated by the Provider:

- Medicines required for acute treatment;
- When initiation of treatment is required within 14 days;
- Drugs listed in the formularies as "Red drugs"; not for prescribing in Primary Care;
- Drugs requiring continued monitoring until such time as a GP has formally agreed to Shared Care;
- Drugs classified as 'specialist initiation' in the formularies.

Where a clinician sees a patient and deems that treatment is not required urgently, the Service should ensure that the GP receives written notification of the treatment

within 7 days and that the patient is advised to contact the surgery after 14 days.

The Service is expected to retain prescribing responsibility for medicines where:

- The medicine has been commenced by the MSK service and needs specialist on-going intervention and monitoring, i.e. all prescribing of 'red' formulary drugs;
- On-going prescribing has not been formally agreed by the GP for a shared care drug;
- The GP does not feel confident in taking on clinical responsibility for the prescribing of a shared care any drug;
- Medicines not listed in the formularies are requested.

Patients requiring biologic treatments will have them supplied and administered on site if they require intravenous injection or infusion. The MSK Service will arrange for biologic treatments requiring subcutaneous injection to be supplied through a homecare company.

Shared Care

It is the responsibility of the MSK Service to request shared care with a GP. The key principle is that the GP is provided with enough information to ensure that the transfer of prescribing or shared care is undertaken safely and given the opportunity to accept prescribing responsibility before the transfer takes place. The sole responsibility for on-going prescribing and monitoring will lie with the initiating MSK Service, if shared care arrangements are not agreed by the GP.

The following conditions must be met before the shared care takes place:

- The drugs are classified as suitable for shared care in the formularies and the responsibilities of all parties are clearly defined;
- Treatment is in accordance with the effective shared care agreement;

If there is disagreement about where prescribing of an individual patient's treatment should best take place, the case should be referred to the CCG Medicines Management teams who will seek resolution between parties concerned. Disagreements over the principles of prescribing responsibility, not individual disagreements that are resolved case by case, should be resolved at the Area Prescribing Committee. Care should be taken to ensure that the patient does not suffer as a consequence and co-operation on both sides is sought in achieving resolution in difficult situations.

Patient Education

The Service should ensure that patients are fully informed of the risks and benefits of treatments recommended to them, and are counselled appropriately on how to use prescribed or recommended medicines.

The Service should train patients requiring biologic treatments for rheumatoid

arthritis and osteoporosis how to self-administer subcutaneous injections where appropriate.

The Service will be expected to develop patient information materials in conjunction with the CCGs' Medicines Management teams.

Financial and Reporting Processes

The Service will be responsible for the costs of all medication, dressings and appliances used to treat patients during a consultation and for the on-going supply of any drugs listed as "red" in the formulary and any drugs where the GP has not agreed to undertake shared care with the following exception:

- The CCGs will reimburse the cost price of the drug plus VAT if applicable of the National Tariff high cost drugs listed in the CCGs' Annual Commissioning Intentions for High Cost and Specialist Drugs provided it is used for the indications specified within the commissioning intentions and it is appropriate for the MSK service to provide this treatment. The MSK service is expected to fully implement patient access schemes (PAS) and ensure that reduced prices arising from discount schemes or free stock are passed on to the CCGs.

The Service is expected to utilise software specified by the Commissioner that will allow a database of patients on shared care medicines and those National Tariff high cost drugs specific to the service, to be built up and to provide surety of compliance with NICE and local guidance. Reporting of the use of these drugs that is compliant with the IG legislation at the time should be provided to the Commissioner on a monthly basis, for reconciliation and monitoring purposes - see the CCGs' annual commissioning intentions for High Cost and Specialist Drugs for further details.

The Service should make arrangements to register as an independent sector healthcare provider and to obtain their own FP10 prescription pads through the NHS Business Services Authority.

Governance

The MSK Service will be able to demonstrate to the Commissioner that robust, auditable systems are in place to cover responsibility, reconciliation, record keeping and disposal requirements for the medicines for which it is responsible. Medicines handling activities (e.g. procurement, storage, prescribing, dispensing and disposal of medicines) will be covered by Standard Operating Procedures and will be safe and in line with current legislation, licensing requirements and good practice, including national guidelines.

All medical, pharmaceutical and health and safety equipment will be regularly maintained and serviced. This will include ECG machines, refrigerators, security and fire alarm systems, nebulisers, sphygmomanometers, and any other equipment used at the Provider site.

3.5 Referrals to Hospital Based Care

Onward Referral for Non-Surgical Care

The following section refers to non-surgical MSK conditions where patients require day case, procedures or referral to other services related to their conditions for example a Neurologist.

The NHS Constitution protects the patients' right to **choose** who provides their hospital care at the point of entry into consultant-led service. In instances where the Service's multi-disciplinary team and the patient feel that day care or another relevant specialist are required for the patient, then the Service will provide **choice** that will facilitate a discussion about the Provider options with the patient and ensure **choice of Provider** is offered. The outcome of these discussions will be captured and the referral made.

Patients' choice will be facilitated by the Shared Decision Making process. Preparation for a day care, obtaining of patient consent (where appropriate), and discharge planning will be undertaken in the MSK Service prior to the intervention taking place. Follow-up and rehabilitation will be provided by the MSK Service. In circumstances when a non-MSK condition is diagnosed then the patient will be referred back to their GP for further management.

Onward Referral for Surgical Intervention

Patients' choice will be facilitated by the Shared Decision Making process. When the MSK multi-disciplinary team and the patient agree that surgery is the preferred treatment option then the Service will offer **choice of surgical Provider** and will capture the outcome of choice discussions. The choice available will be inclusive of all providers on the Choose and Book list.

The fitness for surgery assessment, obtaining of patient consent (where appropriate), Enhanced Recovery processes and discharge planning will be undertaken by the relevant MSK MDT, including the Consultant Medic prior to the surgical procedure taking place. The hospital provider will be responsible for pre-operative and post-operative processes following surgical intervention. For those who require specialist plastic surgery input this will be provided by a Specialist Provider and the MSK Service will ensure that this treatment is sought as appropriate. The MSK Service will be responsible for the post-operative rehabilitation in conjunction with secondary care advice and co-ordination of the patient's care for the routine elective procedures.

Post-operative rehabilitation for Specialist surgery will be the responsibility of the Specialist Provider.

Fit for Surgical Listing and Early Discharge Planning

The objectives for the provision of fit for surgery assessments by the Service are to:

- Ensure that patients are fit for surgery and are willing to go ahead with the procedure that has been agreed as a result of shared decision making;

- Ensure that as far as possible the patient understands the nature, aims and expected outcome of surgery, and that any concerns are addressed;
- Identify any contraindications for surgery and make provision for the patient's health to be optimised before referral;
- Adhere to existing NICE guidelines regarding pre-operative assessment;
- Complete a needs assessment as part of the discharge planning process which identifies intermediate care needs on discharge be that a care package, OT home assessment and arrangement for any equipment, District Nursing input, community physiotherapy provision etc, alongside the potential need for an intermediate care bed. All attempts should be made to co-ordinate the start of these support services with any known discharge dates, particularly when a patient is direct listed for surgery in order to avoid delays in discharge

Any cancellation on medical grounds by the hospital provider will be investigated as a significant event, thereby ensuring appropriate and robust Fit for Surgery assessments with the MSK Service. The exception to this would be where the medical reasons developed after the Fit for Surgery Assessment.

Patients should receive the appropriate fitness for surgery assessment as detailed below:

- That Fit for Surgery assessments within an integrated service will interface with all hospital providers and that there will be no duplication of assessment once the hospital provider has been chosen unless absolutely clinically necessary. The Fit for Surgery health assessment process should therefore be agreed with hospital providers and must be protocol led using best clinical practice;
- Plan for medications to be stopped if necessary prior to surgery;
- Fit for Surgery assessments must follow best practice with regard to informed consent;
- The Service is responsible for the taking of swabs, bloods, ECG, CXR and other tests as required and also for chasing and acting on the results, prescribing where necessary or arranging for referral for clinical action as a response to the results. Fit for Surgery assessments must include MRSA and MSSA testing, and treatment and discharge planning. Where appropriate, discharge planning should include liaison with the family and/or carer and relevant local authority, primary and community care services to ensure that the right services are in place at the right time with the right equipment to facilitate discharge (this may involve home assessment);
- At all stages, opportunities should be sought to offer evidence based health promotion advice and brief intervention to patients. The Fit for Surgery assessment (and treatment planning) should include a full health and lifestyle assessment and support for behavioural change. Generic support with motivation, confidence building and action planning will be provided and referral to other specific support such as smoking cessation, dietetic/weight loss support, exercise referral, will be facilitated as available;

- If a patient is pre-assessed by the MSK MDT and passed as fit for surgery, the patient can be listed directly onto a surgical theatre list if agreed by the Hospital Provider and the Service. This assessment will not include an anaesthetic assessment which will be completed by the Hospital Provider;
- The Service needs to prescribe and arrange for administration and monitoring of appropriate Deep Vein Thrombosis (DVT) prophylaxis peri-operatively inclusive of bridging for warfarin.

Prior to a patient undergoing a surgical procedure, the expected length of stay will have been discussed at the pre-operative assessment appointment and, if the date of surgery is known, a planned discharge date should be known.

The MSK Service must organise and coordinate discharge planning at pre-operative assessment where it will highlight any specific needs that can then be proactively planned and managed to avoid unnecessary delays in discharge. This includes planned provision within an arrangement of external community provider of intermediate care services at home to patients that require extra support on discharge or planned provision of a community step down bed as necessary.

If a patient only requires physiotherapy as part of the discharge plan then this is included within the MSK Service even if this requires domiciliary visits. If the patient has complex needs requiring care from multiple services, then the care will be planned and delivered in integrated partnership with the other care services.

Patients are encouraged to participate in their care to facilitate the planned discharge to go ahead.

Enhanced Recovery

Enhanced Recovery is an evidence based approach involving a selected number of individual interventions which, when implemented as a group, demonstrate a greater impact on outcomes than when implemented as individual interventions. Enhanced Recovery empowers the patient to be a partner in their own care and have greater choice through shared and informed decision making; this starts at the point of referral when assessing the individual needs of a patient prior to surgery and continues where an Enhanced Recovery pathway is chosen, with the management of personalised patient care during and after surgery. The essential components of Enhanced Recovery are that:

- The patient is in the best possible condition for surgery
- The patient has the best possible management during and after his/her operation
- The patient experiences the best post-operative rehabilitation

The Commissioner expects the MSK Service to deliver all the elements of Enhanced Recovery in conjunction with the Hospital Provider who will undertake the surgery.

3.6	**Follow Up and Rehabilitation** Follow up care following a hospital inpatient or day patient intervention will be coordinated and undertaken as appropriate by the MSK team who assessed the need for the required hospital procedure. **Single Point of Access Function** All patients discharged from hospital care will have a single point of access into the MSK Service to ensure co-ordination and continuity of care. This will include follow up against defined protocols of care, rehabilitation and longer term follow up for patients with complex needs and co-morbidities. The Service will provide physiotherapy treatment and rehabilitation in the most appropriate location for the patient. The provision of intermediate care services will remain outside of the MSK Service although the Service will be required to develop and maintain effective relationships with the Providers of the intermediate care services, so that the Service is able to seamlessly manage appropriate patient transition from the secondary care provider to the intermediate care provider The Service will be required to input and to provide information to the National Joint Registry to help define, improve and maintain the quality of care of individuals receiving hip, knee and ankle joint replacement surgery across the NHS. The Service will be required to input and to provide information to any other relevant National Registry or minimum data sets. As individuals will receive their longer term follow up after intervention in the community service, it will be necessary for the Service to capture information relating to their progress to help build the evidence base within MSK services.
3.7	**Domiciliary Service** A domiciliary service must be available for patients who, due to their health needs, are unable to attend either a MSK hub or spoke. The Service will provide a home visiting physiotherapy service for hyper acute patients and those for which this forms part of the discharge protocol. The Service will also provide a domiciliary specialist Occupational Therapist and physiotherapy service to patients with chronic Rheumatological conditions who would benefit from a home or workplace assessment. MSK Podiatry services should undertake domiciliary service to house-bound patients. Equipment required at home is not within the Service. Good links with social care are required.

3.8	**Discharge from the Service** Discharge occurs when the MSK clinical service achieves a point where no further evidence based interventions are available to the patient within their MSK pathway. The patient is directed back to the referring GP or alternative healthcare professional. At the point of discharge from the MSK Service, the Service will be required to produce an electronic discharge document that will contain an account of the assessment, diagnostic tests, treatment plan, treatments carried out and outcomes from the service. It must also include any medications started, stopped or adjusted with the reason on the discharge summary. It would include an on-going supported self-management plan that has been agreed with the patient. A copy will be held by both the patient and the GP. In the case of complex patients a copy of the self-management plan would be made available to information sharing systems (such as IBIS) wherever possible to support access by any health professional that needs to know, such as out of hours doctors, ambulance service, Emergency Department and Out Patient Department as well as the GP and patient to ensure a consistent onward management plan. A self-referral function enables a patient access back by telephone initially into the service within a six month period for the same condition as referred originally. This will support patients, including managing flares of their condition, thus reducing attendance in Emergency departments. The MSK Service will develop a liaison with return to work support schemes locally such as work choice and work programme to support patients to return to work or develop new job skills as appropriate.
4.0	**Interdependence with Other Services/Providers** In order for the Integrated MSK Service to achieve successful outcomes, it is expected the Service will closely relate to other services and integrate where it will provide improved outcomes for patients. The Service is expected to forge proven and effective relationships with the following: • Patient representative groups including support groups; • Professional bodies; • Health and Social Care partner provider services, including Employment support services; • Third Sector services. e.g. support groups and return to work support services; • Falls Services; • (Sub) contracted service providers; • Tertiary and Specialised Services providers; • Primary Care; • Intermediate Care Services, Psychological Therapy services, Health and Wellbeing Services; • Substance Misuse Services (SMS) **Trauma**

	The Commissioner has continued to commission trauma and acute care from the current providers and the full intention is for this to continue in a sustainable manner. The Service will ensure collaboration and integrated working with current acute providers which serve this population to ensure that the Trauma Unit and Trauma Centre are sustained. Sustainability will require services to work together to ensure full continued provision of appropriate clinical workforce (capacity and competency) across all professions, which may be delivered through sharing of resources and training and contribution to the required on-call rotas. This sustainability will in effect underwrite the local trauma services provision to the nationally mandated standards of care and outcomes for patients at least until such time as any revised service configurations resulting from implementations derived from the 2013 Urgent and Emergency Care Review have been fully completed and assured as being sustainable in their own right. **Specialised Services** Specialised services are provided in a number of hospitals for the population served by this Integrated MSK Service. The Service must develop pathways of care that will ensure equality of access to specialised services and it will also be required to work collaboratively with the Providers of specialised services to ensure sustainability.
5	**Quality**
5.1	**Patient and Carer Information** Clear and detailed information to patients to support an informed patient pathway. A variety of current and innovative methods of conveying patient information will be developed that GPs and health professions within the MSK Service can share with patients in primary care, e.g. patient leaflets, websites and exercise videos. Methods will be available in a format that takes into account patient needs, e.g. in different languages. Patients will be sent full personalised information prior to any appointment to maximise their experience and health gain obtained at any appointment. This would include a time, date, place and directions or the ability to arrange this at the patient's convenience. The information should also include the role of the person or persons that the patient will meet, any questions that they might be asked, what might happen at the appointment and so on. The Service should also provide information about the service and send reminders of appointment, for example via email or SMS to reduce incidence of DNAs. The Service will use innovative ways of providing information and resources for patients and their carers, for example, use of information websites and links to patient organisations and support groups as well as Carer Liaison Services.

	At all stages of the pathway, patients will be provided copies of letters and reports with covering explanation if needed. The Commissioner considers that Shared Decision Making is an essential process in the MSK Service, ensuring that every patient and their carers will be enabled to be an equal partner in the care, and understand their options. Training of MSK staff, opportunities to empower key stakeholders, effective management of the Information Hub, and the relevant decision aids will support, facilitate and embed the Shared Decision Making process.
5.2	**Patient Experience** The MSK Service will form effective relationships with Patient and Public through existing mechanisms. The MSK service will implement patients' experience surveys including 'Real Time Patient Surveys'. These surveys will include: • Regular evaluation reports detailing the results of the surveys including the key themes that are emerging and the delivery of action plans to address concerns and issues raised by patients, service users and carers; • This will also include the Patient Reported Outcomes Measures (PROMS) or MPROM when available and any other similar tools for other conditions as defined by Commissioner. The usage and evaluation and further design will be developed on an annual basis; • Distribution of the report to Commissioner, patients and other stakeholders as agreed with the Commissioner; • Evidence of active and continual patient and carer involvement in the review and redesign of service provision; • Evaluation of Shared Decision Making using the SURE tool; • Evaluation of readiness for change and self-management success with the Patient Activation Measure; • Compliance with requirements of the Friends and Family Test initiative
5.3	**Complaints and Plaudits** The MSK service must provide robust integrated governance process for patient complaints and plaudits and for staff to raise patient safety and MSK Service concerns across all suppliers. Compliance with the standard NHS contract for complaints and plaudits will be required.
5.4	**Governance and Incident Management** The MSK Prime Contractor will have a robust governance process in place monitoring and responding to quality issues. The structure will ensure the quality of care the sub-contractors used by the Prime Provider is of a high standard and any concerns are identified, reported and acted upon, informing the Commissioner at the earliest opportunity. The Prime Provider will ensure processes are in place for safe management of multiple MSK pathways that may be in place within some sub-

	contractor organisations. Raising, recording and managing patient safety Incidents (PSIs) and Serious Incidents (SI), in line the standard NHS contract, with national and regional policies and frameworks laid out by the National Patient Safety Agency will be an essential role for the Prime Contractor. Each SI will be followed up by a formal investigation and action plan with the Commissioner being updated on progress. There will be evidence of Board to floor capacity and capability, measuring quality and safety management practices. The Prime Contractor will ensure that there is a process for all SIs either directly or sub-contracted are logged on the national STEIS database. An annual report of all incidents will be submitted to the Commissioner. This annual report should include evidence of undertaking learning from the incident and how learning from incidents has led to improvement in the quality and standard of care for patients.

5.5	**Safeguarding the needs of Children and Vulnerable Adults** In line with the standard NHS contract, the Service will demonstrate robust governance processes in meeting the statutory requirements, the national policy drivers and local policy drivers for safeguarding children and adults, including specific roles for named and designated leads. The Service will have processes in place to ensure staff are trained to the required levels and there is a process in place to ensure staff know how to raise Safeguarding alerts, and (for adults) complies with the pan-Sussex Multi-Agency Policy and Procedure for Safeguarding Adults at Risk, and equivalent processes for Child Safeguarding.
5.6	**Safety Alerts** The Service will have a system in place to ensure national safety alerts (including medicine alerts, medical devices, estates and facilities) are received, disseminated and implemented in line with the required actions.
5.7	**NICE Guidance** The Service must follow the standard NHS contract and ensure compliance with NICE guidance and that updated technical appraisals relevant to the service are reviewed and applied as appropriate to the service.
5.8	**Infection Prevention and Control** The Prime Provider, together with any other sub-contracted services, will ensure risks in relation to the prevention of Health Care Associated Infections and communicable diseases are minimised. There will be effective clinical leadership to ensure required standards are met.
6	**Equality, Sustainability (Environmental) and Social Value**
	The MSK Service will follow the standard NHS contract and achieve equality, sustainable with social value the MSK Service will need to ensure that it: • Provides access to the right care in the right place by the right person; • Establishes standards for quality of care within an effective and integrated service/network; • Improves patient care and outcomes from the MSK Service; • Maximises prevention, either as part of the Service or another closely related service; • Reduces supply induced demand, by ensuring that need has been demonstrated; • Uses best available evidence of effectiveness in deciding details of service design and local population need
6.1	**Equality**

	The Commissioner is mindful of the obligations under the Equality Act 2010 to provide equal access to services and public functions. As a public sector body it has due regard to the need to eliminate any conduct prohibited by the Act; advance equality of opportunity; and foster good relations between those with protected characteristics and those without. The Service will be required to show at all times that it meets its obligations under the Equality Act. The 'whole pathway approach' in the MSK Service will be for those aged 17 years and over and there will need to be a provision for patients who require transition from paediatric to adult services. Patient choice for those aged 16-18 will be respected where some patients may be better served by adult or paediatric services. Given demonstrable interface with Younger People services, in respect of programme management, the Commissioner has considered on the grounds of age it is appropriate and justified to commission the MSK Service for people within the given age group.
6.2	**Social Value** The Public Services (Social Value) Act 2012 requires commissioners of public services to consider how their commissioned services might improve the economic, social and environmental wellbeing of the relevant area; and how in conducting the process of procurement, they might act with a view to securing that improvement. The Commissioner expects the MSK Service to promote wellbeing, health inclusion and employment of local people and communities. Adopting an approach based on social value principles requires a change to the traditional mind-set of the care system from one which sees communities and people having needs, to one which understands and empowers them as having assets that contribute to our health and wellbeing. Social value benefits could be achieved through early intervention and education possibly resulting in earlier return to work and reduction in demand for public services.
6.3	**Sustainability** The new Service will be required to show how it will deliver a sustainable service in line with the requirements set out by the Sustainable Development Unit http://www.sduhealth.org.uk/. There are 5 principles which need to be taken into account: 1. Living within environmental limits; 2. Ensuring a strong, healthy and just society; 3. Achieving a sustainable economy; 4. Using sound science responsibly; 5. Promoting good governance.
7	**Armed Forces**

	In accordance with the requirements of: • The Armed Forces Act 2011: Annual duty to report progress against the Military Covenant to Parliament including Health • Health and Social Care Bill 2011 • NHS Mental Health Strategy 2011 The Service must meet the spirit of the Community Covenant in working together with Military, to improve the health of veterans, serving personal and their families. • The Service must ensure that military veterans receive appropriate treatment, ensuring a smooth transition for injured personnel into NHS care as well as providing priority treatment for conditions relating to their service. Veterans at their first outpatient appointment will be scheduled for treatment quicker than other patients of similar clinical priority. • 'No disadvantage' means veterans/serving personnel and family should not lose their place on a hospital waiting list as they move house across the UK. If an individual moves within the UK, previous waiting time will be taken into account, with the expectation that treatment will be within national waiting time standards (i.e. maximum 18 weeks). A veteran is an individual who has served as a member of the regular services, voluntary reserve and national service. The Service should ensure the organisations are supportive towards those members of staff who volunteer for reserve duties.
8	**Out of Scope**
	The Commissioner considers that some services could be vulnerable as a result of the commissioning of Integrated MSK Services, such as osteoporosis and non-MSK Pain Management. Therefore, to mitigate for the impact of the service changes, these services have been included within the scope of the service.
8.1	**Services out of Scope** The following are out of scope of the Service: • Intermediate Care – although an effective partnership would be expected; • Children aged 16 and under (except exceptional circumstances where appropriate choice is invoked) • Specialised Commissioned Services (NHS England)
8.2	**Condition and Treatment Exclusions** Patients with the following conditions will be excluded from the MSK Service:

	• Immediate life threatening conditions; • Suspected cancers - 2 week wait rule; • Acute trauma, e.g. RTA or falls from a significant height, still in the acute phase; • Patients with red flag symptoms, e.g. cauda equina, systemically unwell, significant weight loss, suggestions of serious infection or malignancy; • Widespread neurology with or without upper motor neurone signs; • Fracture Liaison services – there needs to be effective partnership between both primary and secondary care within the MSK Service particularly with the relationship to the osteoporosis pathway; • Chiropody • Neurological, cardiorespiratory, amputee physiotherapy; • Falls service; • Patients needing Emergency Department; • Headaches – except of cervicogenic origin; • Intermediate care services; Any service or activity related to any service that the MSK Service wishes to provide and is not contained within this Service Specification will not be funded by the Commissioner unless agreed with the Commissioner in advance. Where the Commissioner wishes to de-commission any service contained within this Specification, this will be in accordance with the agreed terms of the contract. These exclusions will be reviewed on a bi-annual basis.
8.3	**Semi-Elective Trauma** Semi-elective trauma is excluded from the Service, but it is an aspirational aim that the Service will accept semi-elective trauma referrals once it has been successfully established and is performing to the desired levels. An example of this would be a patient who has suffered a fracture but does not require treatment of that fracture on an emergency basis.
8.4	**Cancer Pathways** Patients with suspected cancer are referred by their GP under 2 week wait rules and provision for these referrals is not included within the Integrated MSK Service. If there is an incidental finding of cancer the MSK Service will need to have local agreements in place with acute Trusts to allow an urgent referral to be made to an acute provider which can be converted once received on to a 32 day pathway. The MSK Service needs to ensure immediate electronic referral, with acknowledgement of receipt from the Provider of cancer services (i.e. ensuring fast and safe clinical governance). In addition the Service needs to ensure immediate notification to the GP by e mail/fax and immediate notification to the patient with explanation.

9	**Thresholds**
	Referral into the Integrated MSK Service is initiated when a GP (or other authorised clinician) directs a patient to the service in order to obtain advice or access to services. The referral is completed electronically where possible in accordance with agreed protocols and care pathways. A suitably qualified healthcare professional will triage the referral within 1 working day and direct the patient to the most appropriate health professional within the Integrated MSK Service. If the referral is not appropriate for the Integrated MSK Service, the patient will be referred directly to the other appropriate service provider or discharged to the referring clinician. Feedback to the GP is provided as per protocol. The Referral Management information is provided to the Commissioner who will seek to monitor and establish any particular learning needs for healthcare professionals and the MSK service generally. The MSK threshold is normally met when any MSK related interventions by way of 'Self Care' or those led in 'Primary Care' are assessed to be no longer clinically sufficient or appropriate for the patient. The referring clinician will have completed a minimum level of workup in accordance with accepted best practice and the specific pathway requirements and referral threshold for the patient's condition. Treatment thresholds are applied within the MSK Service in line with the agreed care pathways or when referral to consultant-led care is required and will be in accordance with best practice.
10	**Emergency Preparedness; Business Continuity Plan**
	The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services. This programme of work is referred to in the health community as emergency preparedness, resilience and response (EPRR). New arrangements for local health EPRR form some of the changes the Health and Social Care Act 2012 is making to the health system in England. The Prime Contractor must have an Accountable Emergency Officer. The Accountable Emergency Officer in each organisation is responsible for making sure the national core standards are met. The Prime Contractor will produce and agree with the Commissioner an appropriate

	Emergency Preparedness and Business Continuity Plan.
11	**Finance**
	To achieve the best possible outcomes for the patients requiring MSK services, the Commissioner decided that a public procurement process appointing a Prime Contractor would deliver the highest possible value Integrated MSK care. The Commissioner therefore expects the Prime Contractor to demonstrate a credible approach to engaging patients and representative groups in design and delivery of services, and fundamentally offer the best fit for delivery of integration. The financial approach for the Integrated MSK Prime Contractor is a Programme Budget approach. The financial approach will support the financial sustainability of the Prime Contractor to undertake the full range of MSK activity either through directly providing or subcontracting arrangements. The financial approach must demonstrate Value for Money for the Commissioner.
12	**Estates**
	The MSK Service will be delivered from various geographically convenient locations with at least one hub to be mandated within each of the CCGs. The spokes will be in a variety of geographical locations that will deliver services in the heart of people's communities. Each hub or spoke site must have adequate parking facilities including those for the disabled, accessibility for hospital transport and public transport stops must be considered. Premises will be in locations that best meet local need and reduce health inequalities as well as improve equity of access. Commissioner reserve the right to mandate the use of specific locations and sites.
13	**Information Technology**
	There is a need for a fully integrated digital patient record across the whole of the Service. The Service needs to meet national standards, data security and interoperability with other systems. It is important that the NHS Number is the primary identifier on patient data. It will be part of the NHS England contract from 2014. There is a requirement to ensure the safe sharing of data and information between clinicians and with patients. The IT system needs to cope with personnel and clinicians who will work across organisational boundaries. There is a requirement to support patients and public to take more control of their health and care. Both depend on making the best use of digital technologies. This should be supported by

web based patient education information and web based consultations.

The Service needs to make the digital transformation of health and care a focus for innovation and enterprise. The expectations are to achieve the change that all patients' notes are kept electronically.

Achieving an integrated digital care record supports the objectives of the Integrated MSK Service. The Service must be able to ensure IEP and PACs are available for image transfer. It is the MSK Service's responsibility to forward electronic images and reports to the patient's choice of Secondary Care Provider should onward referral be necessary.

The Service with patient prior consent should provide Shared Management Plans readily accessible by patient and clinicians through an Information Hub.

Referrals triage and discharge letters must be electronic. The Service will have a single computer based booking system for the Service. There needs to be provision for email and telephone consultations as appropriate.

To aid the patients' engagement and feedback in the service the Service will undertake real time patient surveys. To aid innovation, development and improvement in patient care the Service needs to capture concerns and plaudits through soft intelligence tools.

The Provider must comply with data standards as defined by the Commissioner.

Please note minimum encryption level of 1024 bit AES and https is to be used for the Integrated MSK Service.

The Provider must complete the Department of Health IG Toolkit submission and demonstrate achievement of level 2 or higher.

The Provider must acknowledge the role of SCCI and comply with any mandated changes specified by the SCCI during the period of the contract.

The Provider must cooperate with all National application service providers, national infrastructure service providers that are responsible for, among others:

- Choose and Book (or equivalent system); use of the Directly Bookable Service (DBS) for all patient referrals into secondary care
- GP systems e.g. SystmOne, EMIS, Vision and others
- NHS Summary Care Records plus ensure that all patient records are kept in the national compatible format and when available to communicate with the national spine services
- Electronic Transfer of Prescriptions; use of the electronic prescribing service for supply, administration and recording of medications prescribed and

	transmission to the Prescription Pricing Division (PPD) • Patient Demographic Service; use of the PDS to obtain and verify NHS Numbers for patients and ensure their use in all clinical communications • NHSMail; use of the NHSMail email service for all email communications concerning patient-identifiable information • N3; use of the national network for all external system connections to enable communication and facilitate the flow of patient information Any moderations to existing NHS site infrastructure can only be carried out upon approved by the Commissioner's IM&T team, exceptions are changes made on sites which the Prime Provider has sole occupancy. Supply and installation of new hardware and any costs associated with this, including IT setup costs incurred as part of the mobilisation plan is the responsibility of the Prime Provider. The Prime Provider is expected to undertake a full SLA for IT support of the service, either by performing this task directly or sub-contracting to another supplier. This SLA is expected to be aligned with the premises and operating times. The provision of new user accounts and dedicated systems training of staff members employed (directly or via other arrangements) by the service is the responsibility of the Prime Provider. The Provider will have a detailed business continuity plan in the event of systems failure and this plan should be made available to all members of the Service. Helpdesk to helpdesk process will be established between Prime Provider IT support and GP practice helpdesk support. The Prime Provider ensures that any changes to pathways, patient information; general guidance and referral forms are cascaded through the Commissioner's editorial team for population on the GP content management solution (currently DXS, Grace & Harmless).
14	**Workforce, Training and Education**
	Robust integrated governance arrangements should be in place to ensure the workforce is of sufficient size to have the capacity and capability to meet the range of services effectively and efficiently. There must be clearly defined structures of accountability and responsible safe service delivery. The necessary staff assistance will be made available to patients at all times and Integrated MSK Service providers must ensure that the appropriate support, training and development requirements of all staff are met, in order to deliver the service

consistently throughout the length of the contract.

The MSK Service will be required to ensure the required workforce policies, strategies, processes and practices comply with all relevant employment legislation applicable in the UK and also comply with the provisions outlined in:

- Safer Recruitment – A Guide for NHS Employers (May 2005);
- The Code of Practice for the International Recruitment of Healthcare Professionals (December 2004) (the Code of Practice); and
- NHS Employment Check Standards (updated July 2013).

The MSK Service will ensure that employment practice is adhered to, to provide assurance of qualified staff, supervision, performance management, appraisal and personal development. The MSK Service will ensure that all staffing incidents are dealt with in a timely fashion, following the relevant organisational policies and procedures and ensuring appropriate staff engagement.

In accordance with best practice the MSK Service will provide opportunities and placements for existing and new learners in training to gain work based experience within the Service, with appropriate supervision by accredited trainers to the standards set with the relevant training and governing bodies. The MSK Service will require that staff members adhere to and demonstrate the NHS Values to ensure that students are exposed to effective role models in practice.

All non-clinical staff members will have the training and development they require to deliver the services in a way such that patients receive compassionate, efficient and empathetic care.

Working with Education England and other agencies, the Service considers Apprenticeship Schemes (or equivalents) as way of sustaining a workforce for the future which provides the skills required.

The MSK Service will train and develop their staff, which will include protected time for high quality training and ensures sufficient staff members are available to teach and assess students in practice.

The Service as an employer has the responsibility to fund and organise statutory and mandatory training as well as ensuring Continued Professional Development (CPD).

Time is required to ensure supervision and support needs are provided for all staff and to ensure that skills and competencies are developed and maintained. There should be opportunities for debriefing and learning when situations arise.

The Service will also provide support and education for clinicians in other specialties to enhance care that patients are receiving and reduce the need for consultant to consultant referrals for example into the Pain Management Specialty.

	The MSK Service will support and encourage GP and other primary care staff education to ensure that there is a good understanding in MSK conditions particularly with respect to early diagnosis and referral. The MSK Service will provide training in all the MSK disciplines e.g. Orthopaedics, Rheumatology, Pain Management, Podiatry, Physiotherapy, Specialist Rheumatology OT for all the workforce i.e. Doctors, GPs, Nurse Specialists, ESPs, Physiotherapists, Podiatrists etc, for trainees in those fields according to their individual requirements. This includes employing and training the recognised Trainers in all those fields as well as working closely with Health Education KSS. The MSK Service will record and maintain a completed training record. **Education and Training** The Integrated MSK Service Prime Contractor will support the education and training ethos of Health Education Kent Surrey and Sussex (HEKSS). It will work collaboratively with HEKSS to implement a cohesive strategy on education and training. The HEKSS Learning and Development Agreement outlines the roles and responsibilities for workforce and education, and a Practice Placement Agreement with local providers of Higher Education which outlines the standards for supporting students in practice. To support the sustainability of a high quality workforce, the Service as part of the requirements of the Learning and Development Agreement will provide Health Education Kent Surrey and Sussex with workforce information to ensure security of supply. The Health Education England Directions 2013 (National Health Service, England on behalf of the Secretary of State for Health) in Section 2(5) sets out the functions that will aid this and in Section 3(2) the priorities and planning for the delivery of the education and training to healthcare workers. In order to support a sustainable Trauma services and specialised provision the Service will work with other organisations to ensure the workforce maintains the skills, training and development to deliver the required services. It will also enable the workforce to work across organisations when required to enable on-call, rotas and services to be delivered.
15	**Research, Audit and Development**
	The MSK Service will undertake learning and development of MSK practice through research and audit activities. All staff, patients, carers and other stakeholders will be offered an opportunity to be engaged in learning and development, as it will aid and demonstrate innovation.

	The MSK Service will demonstrate annually to the Commissioner: • How it has considered and responded to the approved clinical trials, clinical audit and other well designed studies • How it has governed and recruited into clinical trials and other well designed studies over the previous year including remedial actions for improving recruitment into approved trials and other well designed studies as needed • How the MSK service reviewed and acted on the outcome of audit
16	**Information Governance**
	The Commissioner expects a highly distributed approach to the sharing of information across the MSK Service. This aspect of the service delivery supports: • Shared care across pathways including NHS, social care and third sector • Support for the management of care pathways across an integrated clinical system, and monitoring adherence and outcomes • Providing a clear line of sight through the MSK system for clinicians and patients alike In light of the challenges this presents, the Commissioner expects robustly managed access to systems, particularly because staff are employed by multiple organisations. The following approach to managing information security will be demonstrated: • Registration with the Information Commissioner's Office and a minimum level 2 performance against all requirements in the relevant NHS Information Governance Toolkit • Robust Information Governance framework • Privacy Impact Assessments • Patient consent • Information sharing agreements • Secure systems • System access audits As patient information must be managed securely and confidentially within the Integrated MSK Service, all staff will be trained to the Information Governance policies they will work to. The Provider should demonstrate how it will comply with its duties under the DPA and the FOIA and give reasonable assistance where appropriate or necessary to enable the Commissioner to comply with its own duties.
17	**CQUIN**

	Whereas the Programme Budget excludes any payment issued to the Prime Provider under CQUIN, the Commissioner will be negotiating applicable CQUIN goals with the Prime Provider in the duration of the contract. The Commissioner believes that patients can have a first class person-centred MSK Service, and will be negotiating CQUIN goals with the Prime Provider to help transform how people make choices about their healthcare, how they access their healthcare, and the way this is delivered.

KEY PERFORMANCE INDICATORS AND DATA SUBSET

Critical success factors have been developed to ensure the MSK Service is successful in delivering the change required for service users. Measurement against these will be achieved through Key Performance Indicators (KPSs). These will inform the Commissioner of progress and will provide an alert to areas of non-compliance. Section A below details the proposed KPIs that will be used to manage the contract. Underneath the KPIs will be a more detailed dataset established between the MSK Prime Contractor and Commissioner to monitor progress and provide potential areas of success/failure. These will not be used as a contractual lever, however if continually identifying poor performance, may be escalated to a KPI.

The list identified in both sections will be developed further with the Prime Contractor during mobilisation.

Section A – Key Performance Indicators: Selected KPIs are listed below under each critical success factor

Title	Purpose	Stage in Care	Target	Formula	Frequency	Who measures?	Source of data	Who takes action?	What do they do?
CRITICAL SUCCESS FACTOR 1 **Improved patient experience and service quality for MSK patients and their carers through care organised around the patient through:** • **Shared Decision Making** • **Patient Choice**									

Title	Purpose	Stage in Care	Target	Formula	Frequency	Who measures?	Source of data	Who takes action?	What do they do?
1. Patient reported outcome measures (PROMS)	To determine the quality of the MSK service through measuring patient perception of their treatment outcome. This will be through specific PROMS for each of the main pathways: Rheumatology, Pain, Hip and Knee, foot and ankle, shoulder and elbow, hand and wrist, and spine	All stages	Please provide the proposed PROMS to be used (National must be used where available). Please add improvement trajectory		Quarterly	Contractor			
2. Patient reported experience measures (PREMS)	To determine if patients have a good experience of using the service. This will be through the use of PREMS for each main pathways and must include experience in shared decision making and patient choice	All stages	The contractor can use established or design specific tools to measure patient experience at all stages of service, in discussion with Commissioner. Please add improvement trajectory and provide the proposed PREMS (National must be used where available).		Quarterly	Contractor			
CRITICAL SUCCESS FACTOR 2									

Title	Purpose	Stage in Care	Target	Formula	Frequency	Who measures?	Source of data	Who takes action?	What do they do?
Services delivered are sensitive to local health and service need, as defined in local outcome specifications including: • **Access** • **Local population**									
3. The provision of services are local to patients	A measure of activity by geographical location for treatment or assessment linked to the referral location to determine the accessibility for services.	All stages	Prime Provider to determine how measured to include: • Minimum 90% patients satisfied with location of treatment offered • Minimum 90% satisfied with patient choice		Quarterly	Contractor			
4. Patients are receiving treatment within required timescales	To ensure that patients receive their treatment within acceptable timeframes	Stage 2: MSK Portal and Out-patient services	• 90% of patients commence their first treatment within a minimum of 8 weeks from receipt of referral • RTT18 Target • 6 week diagnostic target • Please add improvement trajectory		Quarterly	Contractor			
CRITICAL SUCCESS FACTOR 3 **People are supported to maintain their independence, by providing preventative interventions thus reducing avoidable admissions, re-admissions and extended stays in acute hospitals.**									

Title	Purpose	Stage in Care	Target	Formula	Frequency	Who measures?	Source of data	Who takes action?	What do they do?
Achieved through: • **Shared Care Plans** • **Supported self-management**									
5. All patients have a shared care plan to include self-management	To ensure patients are supported to understand their management plan.	Stage 2: MSK Portal and Out-patient services	• Minimum of 80% of patients should have a shared care plan including self-management		Quarterly	Contractor			
6. MSK prevention schemes in use and effective within the community	To ensure MSK prevention schemes in place and working – Evidence of health promotion.	Stage 1 – Primary Care and Self-Management	• Number of schemes in place – Provider to determine minimum measure • Reduction in MSK cases		Quarterly	Contractor			
CRITICAL SUCCESS FACTOR 4 **Will have moved beyond traditional organisational and professional boundaries, so front-line staff can work effectively and flexibly to deliver seamless care ensuring:** • **Right person, right time, right place** • **Training and education**									
7. Quality of triage process	To ensure the patient receives the right care at the right time. This will be monitored through the effectiveness of triage system.	Stage 2: MSK Portal and Out-patient services	• Data reports of patient flow through the system • GP satisfaction reports (within another KPI) • Patient experience questionnaires						

Title	Purpose	Stage in Care	Target	Formula	Frequency	Who measures?	Source of data	Who takes action?	What do they do?
8. Staff satisfaction and engagement of working within MSK service	To assess the view of all MSK staff on their experience of working within the service to ensure they feel valued and supported in their role. This will be through engagement sessions and staff surveys	All stages	Provider to include minimum improvement trajectory		Six Months then annually	Contractor			
9. GP Experience	To assess the satisfaction of service for GPs through survey	All stages	Minimum 80% satisfaction		Six Months then annually	Contractor			
CRITICAL SUCCESS FACTOR 5 **Delivered an organisational solution for MSK care which can demonstrate strong leadership, sound governance, resilience and the confidence of Commissioner and Provider partners**									
10. Waiting and treatment times reduced to a minimum	To ensure patients using the service receive treatment in the fastest possible timeframe.	All stages	• Please add improvement trajectory						
11. Responsive to identified problems or areas of poor performance/ safety	Patient safety and performance reviewed for all providers of care and concerns addressed through effective governance meetings and actions	All stages	100% compliance to governance. The committee meetings are conducted in line with organisational structure and terms of reference. Minutes and action plans provided for						

Title	Purpose	Stage in Care	Target	Formula	Frequency	Who measures?	Source of data	Who takes action?	What do they do?
			evidence.						
12. Mandatory and statutory national reporting requirements are met	To ensure all reporting requirements are met and to allow effective monitoring of service performance/quality.	All stages	• 100% national reporting requirements completed		As required nationally	Contractor			
CRITICAL SUCCESS FACTOR 6 **Demonstrated a credible approach to engaging patients and representative groups in design and delivery of services**									
13. Engagement with stakeholders and changes made through feedback sessions	Service user engagement continues throughout the service and identified improvements implemented.	All stages	• Number of engagement sessions. A minimum of 2 separate locations per 6 months • This must include patient representative groups and third sector services		Every 6 months				
CRITICAL SUCCESS FACTOR 7 **Provided a sustainable financial model based on the principles below:** • **Aligning improved patient outcome with financial incentives** • **Sharing financial gain and risk across the Commissioner/Provider system** • **Delivering the recurrent financial balance in a sustainable way** • **Creating the conditions for investment and delivering a return on investment**									
14. Finance KPI to be developed with Prime									

Title	Purpose	Stage in Care	Target	Formula	Frequency	Who measures?	Source of data	Who takes action?	What do they do?
Provider									
CRITICAL SUCCESS FACTOR 8 **Communications which are integrated, timely and effective for:** • **Patients** • **Clinicians** • **Carers**									
15. Information provided at the right time for the right person	To ensure patients, carers and GPs receive the correct information at the right time	All stages	• GP satisfaction survey (see title 9) • Minimum 85% patient satisfaction (survey) • Please add improvement trajectory						
16. Information hub (including website) accessible for patients and health professionals	The information hub is available and up to date for patients, GPs and all health professionals using the service. This will be achieved through patient, GP and staff feedback	All stages	• 85% satisfaction with information portal/website. • Please add improvement trajectory						

Section B – Key Performance Indicators Data Subset

The following indicators are linked to specific Key Performance Indicators and will be monitored by the Commissioner and Provider. The full list will be developed in collaboration with the Preferred Provider prior to the commencement of the contract to ensure effective monitoring of the Service.

Title	Purpose	Stage in Care	Target	Formula	Frequency	Who measures?	Source of data	Who takes action?	What do they do?
CRITICAL SUCCESS FACTOR 1 **Improved patient experience and service quality for MSK patients and their carers through care organised around the patient through:** • **Shared Decision Making** • **Patient Choice**									
KEY PERFORMANCE INDICATORS **Patient reported outcome measures (PROMS)** **Patient reported experience measures (PREMS)**									
1. SURE Score	To ensure patient feels informed about decisions relating to their care		• Please add improvement trajectory		Quarterly				
2. Patient Decision Aid	To ensure the patient is well informed to make decisions relating to their care.	Stage 1 – Primary Care and Self-Management	• Minimum of 80% of patients are using National SDM PDAs where available/appropriate. Please add improvement trajectory		Quarterly	Contractor			
3. Readmission rates within 29 days of surgery	To ensure in patient treatment and discharge process effective through	Stage 3: Inpatient Services and Enhanced	• Please add improvement trajectory		Quarterly	Contractor	TBC		

Title	Purpose	Stage in Care	Target	Formula	Frequency	Who measures?	Source of data	Who takes action?	What do they do?
	reduced readmission	Recovery							
4. Post-operative complications	To ensure in patient treatment and discharge process effective through reduced complications	Stage 3: Inpatient Services and Enhanced Recovery	• Please add improvement trajectory		Quarterly	Contractor	TBC		
CRITICAL SUCCESS FACTOR 2 **Services delivered are sensitive to local health and service need, as defined in local outcome specifications including:** • **Access** • **Local population**									
KEY PERFORMANCE INDICATORS **The provision of services are local to patients** **Patients are receiving treatment within required timescales**									
5. Treatment in one stop clinics	To measure the number of patients who receive treatment and/or diagnosis and treatment plan by the end of their first appointment	Stage 2: MSK Portal and Out-patient services	By the end of their first appointment, 80% of patients will have a diagnosis and either: • Started definitive treatment; • Been discharged with a treatment plan; • Been referred on for treatment with a treatment plan • 60% of diagnostics should be		Quarterly	Contractor			

Title	Purpose	Stage in Care	Target	Formula	Frequency	Who measures?	Source of data	Who takes action?	What do they do?
			performed and reported within a one stop MSK clinic appointment						
CRITICAL SUCCESS FACTOR 3 **People are supported to maintain their independence, by providing preventative interventions thus reducing avoidable admissions, re-admissions and extended stays in acute hospitals.** **Achieved through:** • **Shared Care Plans** • **Supported self-management**									
KEY PERFORMANCE INDICATORS **Shared care plans are used for all patients** **All patients have a self-management plan and are receive support to use them** **MSK prevention schemes in use and effective within the community**									
6. Advice and guidance responses	To ensure that GPs receive a timely response to their question by e mail or telephone to A&G requests and patient's care is not delayed.	Stage 1 – Primary Care and Self-Management	• Routine response within minimum of 3 working days of receipt • Urgent response within 1 working day of receipt.		Monthly for first 6 months then review	Contractor			
7. Self-management plan	To ensure patients are supported to understand their management plan including how to manage flare ups.	Stage 2: MSK Portal and Out-patient services	• Minimum of 80% of patients should have a co-produced self-management plan on discharge that describes their		Quarterly	Contractor			

Title	Purpose	Stage in Care	Target	Formula	Frequency	Who measures?	Source of data	Who takes action?	What do they do?
			on-going self-management and is inclusive of flare management advice including who to contact if necessary, a copy of this is given to the patient and the GP						
CRITICAL SUCCESS FACTOR 4 **Will have moved beyond traditional organisational and professional boundaries, so front-line staff can work effectively and flexibly to deliver seamless care ensuring:** • **Right person, right time, right place** • **Training and education**									
KEY PERFORMANCE INDICATORS **Staff satisfaction and engagement of working within MSK service** **GP Experience**									
8. Clinical staff training in shared decision making and motivational interviewing	To ensure staff have the necessary skills too effectively support shared decision making and carry out motivational interviewing.	Stage 1 – Primary Care and Self-Management	• Please add improvement trajectory		Quarterly	Contractor	Training records maintained by the contractor.		
9. Direct listing of admitted surgery referrals	To ensure patients requiring surgery are treated at the earliest opportunity therefore avoiding unnecessary	Stage 2: MSK Portal and Out-patient services	• 50% of patients requiring admitted surgery are directly listed.		Quarterly	Contractor			

Title	Purpose	Stage in Care	Target	Formula	Frequency	Who measures?	Source of data	Who takes action?	What do they do?
	outpatient appointments		• Please add improvement trajectory						
10. Fitness for surgery assessment	To ensure that all patients have been assessed for surgical fitness prior to surgery thus reducing last minute cancellations of surgery.	Stage 3: Inpatient Services and Enhanced Recovery	• 100% of patients receive a fitness for surgery assessment.		Quarterly	Contractor			
CRITICAL SUCCESS FACTOR 5 **Delivered an organisational solution for MSK care which can demonstrate strong leadership, sound governance, resilience and the confidence of Commissioner and Provider partners**									
KEY PERFORMANCE INDICATORS **Waiting and treatment times reduced to a minimum** **Responsive to identified problems or areas of poor performance/ safety** **National reporting requirements completed**									
11. Complaints are responded to within timely manner.	To ensure patient complaints are promptly addressed,	All stages	• 100% of all complainants will receive an acknowledgement within 3 working days and a formal response within 25 working days. No more than 2% of complaints are referred to the ombudsman. Number of all		Monthly	Contractor			

Title	Purpose	Stage in Care	Target	Formula	Frequency	Who measures?	Source of data	Who takes action?	What do they do?
			complaints and % compliance will be required						
12. Serious Incidents including Never Events requiring investigation are investigated and reported without delay	Timely reporting and escalation of Serious Incidents	All stages	• 100% of SIRIs are reported to Commissioners within 48 hours and have their root cause investigated and reported to Commissioner within: 45 working days for Grade 1 SIRIs and 60 working days for Grade 2.		Monthly	Contractor			
13. Cancer findings sent to MDT pathway without delay	To ensure that patients with incidental findings of cancer are referred without delay	Stage 2: MSK Portal and Out-patient services	• 100% of all incidental findings of cancer sent to cancer MDT pathway by secure means within 1 working day, with acknowledgement of receipt of that referral required within that working day		Monthly	Contractor			

Title	Purpose	Stage in Care	Target	Formula	Frequency	Who measures?	Source of data	Who takes action?	What do they do?
14. GP advised of cancer finding without delay	To ensure that patients with incidental findings of cancer are advised through their GP being informed without delay	Stage 2: MSK Portal and Out-patient services	• 100% GPs informed of the incidental finding of suspected cancer and referral within 1 working day.		Monthly	Contractor			
15. Compliance with NICE Guidelines	To ensure the MSK service is following NICE guidance	All stages	• NICE compliance audit		Annually	Contractor			
CRITICAL SUCCESS FACTOR 6 **Demonstrated a credible approach to engaging patients and representative groups in design and delivery of services**									
KEY PERFORMANCE INDICATORS **Engagement with stakeholders and changes made through feedback sessions**									
16. Initial and on-going engagement with key stakeholders	To ensure the Service is always aligned to service user needs	All stages	Evidence of regular engagement with the following groups: Patient representative groups, professional bodies, Health and Social Care partner provider services, third sector services, falls service, primary care, intermediate care services, psychological therapy services and health and wellbeing		Report provided every six months	Contractor			

Title	Purpose	Stage in Care	Target	Formula	Frequency	Who measures?	Source of data	Who takes action?	What do they do?
			services.						
CRITICAL SUCCESS FACTOR 7 **Provided a sustainable financial model based on the principles below:** • **Aligning improved patient outcome with financial incentives** • **Sharing financial gain and risk across the Commissioner/Provider system** • **Delivering the recurrent financial balance in a sustainable way** • **Creating the conditions for investment and delivering a return on investment**									
KEY PERFORMANCE INDICATORS **Provided a sustainable financial model based on the principles below:** • **aligning improved patient outcome with financial incentives** • **Sharing financial gain and risk across the Commissioner/Provider system** • **Delivering the recurrent financial balance in a sustainable way** **Creating the conditions for investment and delivering a return on investment**									
17. To be established during mobilisation submission									
CRITICAL SUCCESS FACTOR 8 **Communications which are integrated, timely and effective for:** • **Patients** • **Clinicians** • **Carers**									
KEY PERFORMANCE INDICATORS **Information provided at the right time for the right person** **Information hub (including website) accessible for patients and health professionals**									
18. Timely sending of clinic outcome letters	To ensure that patients/carers and their GPs are kept informed about their	Stage 2: MSK Portal and Out-patient services	• 100% of clinic outcome letters should be received by the		Monthly for first 6 months then review	Contractor			

Title	Purpose	Stage in Care	Target	Formula	Frequency	Who measures?	Source of data	Who takes action?	What do they do?
	treatment.		GP within 7 working days of the appointment.						
19. Response following referral	To ensure that patient referrals are reviewed and processed within 1 working day (excluding urgent cancer).	Stage 2: MSK Portal and Out-patient services	• Minimum of 80% referrals to be processed within 1 working day of receipt by the service. • Please add improvement trajectory		Monthly	Contractor			
20. Choice and timely offer of appointment	To ensure that patients are contacted promptly to offer an appointment and that they receive a choice of date/time/location	Stage 2: MSK Portal and Out-patient services	• 95% of patients (excluding cancer cases) are offered an appointment with a choice of date, time and location within 5 working days of receipt of referral •		Quarterly	Contractor			
21. Documented discharge plan prior to surgery	To ensure that patients are clear about their care following a surgical intervention and these plans are put	Stage 3: Inpatient Services and Enhanced Recovery	• 100% of patients have received a documented discharge plan prior to surgery.		Quarterly	Contractor			

Title	Purpose	Stage in Care	Target	Formula	Frequency	Who measures?	Source of data	Who takes action?	What do they do?
	into action This includes any intermediate care needs or step down beds required.								
22. Timely electronic discharge letters	To ensure that GPs are kept informed of their patient's management plan and any on-going care required.	Stage 3: Inpatient Services and Enhanced Recovery	• 100% of discharge letters are electronically sent to GP within 24 hours of the decision to discharge		Quarterly	Contractor			
23. Referral feedback provided to GPs	GPs will be informed of their referral activity in order to reassure/learn from clinical decision making	Stage 1 – Primary Care and Self-Management	• All GPs receive monthly status report		Monthly	Contractor			