Musculoskeletal Service Improvements

1. Using RightCare Methodology "Where to look; What to change; How to change"				
Organisation	**What was the challenge?**	**What was the solution?**	**What were the results?**	**Reference for further info**
Ashford MSK Triage Right Care Casebook Series	• Failing to meet 18 week referral to treatment target. • RightCare highlighted large number of referrals to secondary care. Referrals had increased by 20% over previous financial year. • Significant clinical variation.	• CCG adopted RightCare methodology: Where to look; What to change; How to change. • Examined individual GP data finding significant variation rates of orthopaedic referral to secondary care. • Developed an understanding of the best orthopaedic pathways for patients. • Introduced an MSK triage service. • MSK value for money practice level scorecards for all GPs to demonstrate practice referral behaviour across best-performing practices.	• Referrals to secondary care remain 40% lower than during the pre-triage peak period and slightly lower than baseline. • Annual savings of £1 million, reduction of some 30% referrals into secondary care.	NHSE RightCare Casebook series https://www.england.nhs.uk/rightcare/products/casebooks/
Cumbria Persistent Physical (PPSS) Symptom management service	• RightCare 'Where to Look' pack highlighted MSK services as one of Cumbria CCG's key opportunities for improvement. i.e. High spend on back pain injections and lower spend for radicular pain injections compared to most similar CCGs. & higher admissions/day cases for both. • Pain management service was: expensive; over-medicalised model of care that did not meet NICE guidance; limited integration with physiotherapy and primary care; high intervention rate with all interventions recorded as medical procedures; no access to psychological models of care; accepted referrals directly from GPs with no appropriate local triage.	• A single point of access, via email, whatever the patient's condition and possible diagnosis. • Triage by senior clinicians. • A multi-disciplinary face to face assessment with physiotherapist and senior psychological expert (psychologist, psychological practitioner or CBT therapist), including a review of a self-assessment questionnaire that the patient brings to the first appointment (this has a 96% uptake by patients). • Patients are matched to the right level of therapy e.g. • one to one psychology; CBT therapy, physiotherapy or occupational therapy; or guided self-help with rehabilitation assistant; or patients are offered a group intervention based on CBT, ACT and mindfulness • An eight-week programme for groups with a physiotherapist and senior psychological practitioner (this involves six to seven groups on the go at any one time across North Cumbria).	• High patient satisfaction <6months of new service. • Waiting times increased to around 12 weeks – target was 4 weeks. Attributed to the number of highly complex patients. • Spending on the high cost pain related drug Nabilone has been eliminated with no substation - £90K/annum saving.	https://ppss.cumbria.nhs.uk/

NHS North West Surrey CCG	• RightCare data – CCG MSK spend was significantly higher than peers, gap of £3.3m. • RightCare highlighted CCGs with lower spend had better outcomes. • Medicalised service; clinical variation; incoherent pathways; silo working. • Commissioning for value identified MSK as an outlier compared to 10 similar CCGs. • Patients and GPs expressed concerns that services were disjointed. • Poor patient outcomes.	• Stakeholder consultation exercise. • Biopsychosocial model • Integrated service, providing rapid and comprehensive MSK assessment and treatment services for all adult patients. • Triage by expert teams within 48 hours of the service received the referral and first contact with the service within a 3 week period. • Dedicated helpline for advice and guidance.		http://surreyimsk.com/
2. Integrated MSK services				
Healthshare Hull: NHS Hull CCG	• Long waiting lists for MSK services. • Poor outcomes.	Tendered new contract with Healthshare. 2 hub-sites in Hull where patients are triaged scanned and treated in a single visit if appropriate.	• Reduced GP burden by implementing patient self-referral. • Improved patient choice. • Reduced unnecessary referrals to secondary care. • Reduced diagnostics. • Encouraged patient self-management.	https://healthsharehull.org.uk/
Hammersmith and Fulham CCG	• Long waiting lists for MSK services; fragmented service delivery; lack of innovation and pathway design.	Tendered new contract with Connect Health in May 2016 for: Community MSK physiotherapy services; outpatient orthopaedic and rheumatology services; chronic MSK pain management services.	After first year of service: • 14% reduction in Trauma and Orthopaedic secondary care referrals. • 19% reduction in rheumatology. • 31% reduction in MRI expenditure • 99% reduction in RRT rate despite increased activity, • 85% of patients seen in physio <3 weeks from GP referral.	http://www.connecthealth.co.uk/nhs-community-services/hammersmith-fulham-case-study/

3. Working with Allied Health professionals/Self-referral				
NHS Nottingham & Nottingham CityCare	• Heavy GP caseload. • Issues of workforce training and retention.	• 2 x MSK Physiotherapists introduced as first contact MSK practitioners to provide 2 half day sessions per week in the inner city and university GP practices in Nottingham for 1 year. • Clinical outcome measures: EQ-5D-5L and Global Rating of Change questionnaire.	After 11 months: • 555 patients seen by MSK service • 71% successfully managed by MSK service. • <2% (n=9) referred back to their GP. • Service was at least 6 times cheaper than GP costs.	**Rob.goodwin@nottingham.ac.uk**
Southern Health NHS Foundation Trust	• Heavy GP caseload. • Opportunity to improve patient pathways in MSK. • The need for specialist knowledge in MSK in primary care.	• Extended scope MSK physiotherapist placed in local GP practices.	• MSK physiotherapists manage 64% of patients and refers less than 20% of patients for physiotherapy compared to GP (30%). • Significantly less prescription requests made: 8% to 40%. • Patient satisfaction 100%.	**Neil Langridge, Consultant Physiotherapist Southern Health NHS Foundation Trust** Neil.langridge@southerhealth.nhs.uk
Cheshire and Wirral Partnership Foundation Trust	• Heavy GP caseload. • Opportunity to improve patient pathways in MSK. • Poor communication between GPs and physiotherapists in individual cases. • Poor patient satisfaction with physiotherapist service	• 36 GP practice host a physiotherapy service providing first contact by a MSK Physiotherapist for any patient with suspected MSK condition. • Rapid access to assessment and advice for self-management, referral and on for further physiotherapy or specialist assessment. • 2 x Band 7 Clinical Physiotherapists provided 30 minute assessment/treatment sessions.	During 3 month pilot: • 754 patients accessed the service • 90% of GPs scored the benefits of the PhysioFirst service to be 8/10 or above. • 96% reported the service saved GPs time, allowing them to see more appropriate patients. • Estimated saving of £625,000 a year	**Alison Swanton**
4. Shared decision making (SDM)				
Arthritis Care & Berkshire West CCG	• Need to embed SDM in MSK	• Patients with osteoarthritis of hip and/or knee referred by GP to service. • 3 types of access to the service: face to face/telephone/group.	• Of 642 patients who attended, only 98 chose to have surgery within 2 years. • Saving of £2.6 million	**Dr Rupert Woolley Clinical Lead BW CCG**

		• Patients can discuss differing options for management of their conditions.
		  ○ Gain better understanding of their condition
		  ○ Increase confidence in self-management
		  ○ Provided with access to information to make informed decisions
		  ○ Feel less isolated.
			• Patient satisfaction averaged 98%.	

BMJ Open Access 2017	• Adoption of SDM into routine practice has been remarkably slow, despite 40 years of research and considerable policy support.	• Health Foundation UK commissioned the MAGIC (Making Good Decisions in Collaboration) programme to design, test, and identify the best ways to embed SDM into routine primary and secondary care using QI methods. • Phase 2 – demonstrated that SDM can become part of routine clinical care in Cardiff, and Newcastle.	Recommended solutions: • Interactive skills workshops • Development of brief tools • Patient activation and preparation • Measurement • Organisation buy-in/senior level support • Collaborative and facilitated approach. *** MAGIC resources/interventions listed in this table can be found on the Health Foundation's Person Centred Care Resource Centre: http:// personcentredcare.health.org.uk/ All of the MAGIC materials included on this website are available open access**	**Joseph-Williams Natalie, Lloyd Amy, Edwards Adrian, Stobbart Lynne, Tomson David, Macphail Sheila et al. Implementing shared decision making in the NHS: lessons from the MAGIC programme BMJ 2017; 357 :j1744**