



Right person, right place, first time

Transforming musculoskeletal and orthopaedic elective care services

Case studies





About these case studies

Intervention summary

Part 1:
Elective care 100 day
challenge – Fylde Coast
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Equality and health inequalities

Promoting equality and addressing health inequalities are at the heart of our values. Throughout the development of the policies and processes cited in this document, we have: Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected

characteristic (as cited under the Equality Act 2010) and those who do not share it; and Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Information governance

Organisations need to be mindful of the need to comply with the Data Protection Act 1998, the Common Law Duty of Confidence and Human Rights Act 1998 (Article 8 – right to family life and privacy).

Elective care transformation

Transformation of the GP referral and outpatient process to give a better experience for patients and clinicians and to make better use of resources. Patients should be seen by the **right person, in the right place, first time**.

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please email england.electivecare@nhs.net



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About these case studies

Objectives

Timely access to high quality elective care is a key priority for both NHS England and local health and care systems, as set out in the NHS Constitution. Yet the NHS is experiencing unprecedented and growing demand for elective care.

This case study pack was developed by NHS England's Elective Care Transformation Programme. It provides **practical, evidence-based advice on delivering high quality care for people using MSK elective care services, in the context of rapidly rising demand.**

Its aim is to support commissioners and providers to work together to:

- Better manage rising demand for elective care services
- Improve patient experience and access to care
- Provide more integrated, person-centred care.

How to use these case studies

These case studies are aimed at commissioners and healthcare providers. They provide examples of innovation in the delivery of elective care services and should be used alongside [NHS England's MSK handbook](#), which sets out practical steps for implementing key interventions in MSK.

The pack is split into three parts:

- **Parts one to three** list case studies from NHS England's 100 day challenge programme. These interventions were implemented at pace and show significant early promise, **but have not been subject to long-term evaluation.** As such, **the data presented is primarily focused on process rather than outcomes.**
- **Part Four** showcases selected further case studies and resources to support innovation in the delivery of MSK elective care services.

Timely access to high quality elective care is a key priority for both NHS England and local health and care systems. However, demand for elective care is growing steeply.



These case studies provide practical advice on delivering high quality care for people using MSK elective care services. They are aimed at commissioners and providers.



They should be used alongside [NHS England's MSK handbook](#)



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Intervention summary

These case studies summarise:

- Thirteen interventions tested within **Wave 1 of the Elective Care Development Collaborative 100 day challenge**
- Overview of **selected further case studies**, including references to original documents.

Individual case studies are split into the three broad themes:

Theme	Fylde Coast	Somerset	Stockport	Other case studies
 Rethinking Referrals	<ul style="list-style-type: none">• Standard Referral Template• Self-Referral to MSK physiotherapy	<ul style="list-style-type: none">• Standard Referral Template• GP Education for X-ray Requests		<ul style="list-style-type: none">• The Development of MSK Triage Services• Self-referral to MSK practitioner services• Systematic review of international evidence
 Shared decision making & self-management support	<ul style="list-style-type: none">• MSK self-management education (Joint Venture)• Patient Passport (Self Help Guide)	<ul style="list-style-type: none">• MSK self-management education• Patient Passport	<ul style="list-style-type: none">• MSK self-management education• Patient passport	
 Transforming Outpatients	<ul style="list-style-type: none">• Transforming Opioid Management	<ul style="list-style-type: none">• Patient-Initiated Post-Op Follow-up	<ul style="list-style-type: none">• Telephone follow ups for orthopaedics	<ul style="list-style-type: none">• Virtual Clinics



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Part 1

Elective care 100 day challenge **Fylde Coast** **case studies**



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Local context

The health and care system in Fylde Coast

The Fylde Coast system belongs in the North of England region of NHS England. It includes:

- Blackpool Teaching Hospitals NHS FT (BTH)
- Blackpool CCG (BCCG) with 21 GP practices
- Fylde & Wyre CCG (F&W CCG) with 19 GP practices.

MSK Pathway

The MSK pathway in Fylde Coast is a community-based service which includes a Tier 2 multidisciplinary team consisting of a consultant physiotherapist, extended scope practitioners, a consultant orthopaedic surgeon and a GP, supported by a team of physiotherapists and assistants.

The service acts as a single point of access offering clinical triage of referrals from primary care into T&O and MSK. As part of the Elective Care Transformation Programme, a single standard referral template was tested for T&O, MSK and Pain Management. This extended the single point of access to the Pain Management service.

All primary care referrals in Fylde Coast are made electronically, using the e-Referral System, and sent to the MSK service.

Fylde Coast MSK rapid-testing team

The frontline team comprised the following representatives:

Administrative & Clerical	Clinicians
Head of Delivery & Planning (F&W CCG)	Clinical Lead for Community Musculoskeletal Service
Commissioning Officer – Scheduled Care and Cancer (F&W CCG)	GP Partner (F&W CCG)
Commissioning Projects Officer (BCCG)	MSK & Foot Health Service Manager
Project Manager (Fylde Coast Vanguard)	Consultant Anaesthetist
Head of Therapies (BTH)	
Business Intelligence Manager (F&W CCG)	
Service Support Team Leader for MSK services	



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Improving the quality of referrals: Overview

The challenge

Referrals link a patient's journey from primary to secondary care. As the patient is passed from one setting to another, it is important that referral details are transferred with the patient and in sufficient detail. It is the job of both primary and secondary care to agree what the right pathway for the patient is and what information needs to be provided. Fylde Coast has tested a number of interventions improving the referral process.

The interventions

Standard Referral Template

- **Opportunity:** Reduce inappropriate referrals coming to the specialist service and improve the quality of referral information.
- **Scope:** The template outlines referral information that the MSK service requires to provide the patient with appropriate specialist care.
- **Intervention tested:** The template was drafted by the MSK service in collaboration with primary care. It is available on EMIS with a number of fields pre-populated by the system. A GP completes the rest of the template and attaches it to a referral on ERS.
- **Results:** The MSK service received 155 referrals from pilot practices over the testing period, with more than 90% using the template. Of those, 48% contained a completed template, while the remaining 52% were not filled in completely.

Self-Referral to MSK

- **Opportunity:** Make access to healthcare easier and more flexible for patients while reducing the workload for GPs and strengthening patients' ownership of their condition.
- **Scope:** The intervention allows patients to self-refer to the MSK service (physiotherapy and Pain Management) rather than having to see their GP first to be referred through ERS: the patient books an appointment at a MSK reception desk or over the phone.
- **Intervention tested:** When booking an appointment, a patient provides their personal details. This enables the MSK service to identify the patient on EMIS and access data required for the MSK appointment.
- **Results:** The intervention was due to be tested in Autumn 2017, once the local MSK service was fully staffed.

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Standard referral template: Detail

The challenge

Under the current system, patients are often referred to multiple specialties, including MSK and Pain Management, sometimes with insufficient referral information. This prevents effective triage and results in a number of inappropriate referrals. As a result, it may often take several appointments at various specialties for a patient to find the right person to see.



The intervention

Scope

- The standard referral template is used by primary care as a single point of access for referrals to the MSK, T&O and Pain Management Service. If you would like a copy of a standard referral template please email england.electivecare@nhs.net.
- The MSK triage service triages all referrals to those specialties.
- It is available on EMIS with a number of fields pre-populated by the system. A GP completes the rest of the template and attaches it to a referral on ERS.
- The template was piloted with five GP practices (two in Fylde & Wyre CCG, three in Blackpool CCG).

Planning and preparation

- The template was developed collaboratively by primary and secondary care.
- Before piloting, we introduced the template to local practice managers' bodies (one in each CCG) where it was discussed with all GPs (not only the piloting group).
- The introduction, openness to challenge and reflection of GPs' comments helped to make practices familiar with the template.
- Pilot practices were identified by CCGs on a discretionary basis and were linked to the EMIS team which advised them on access to the template.



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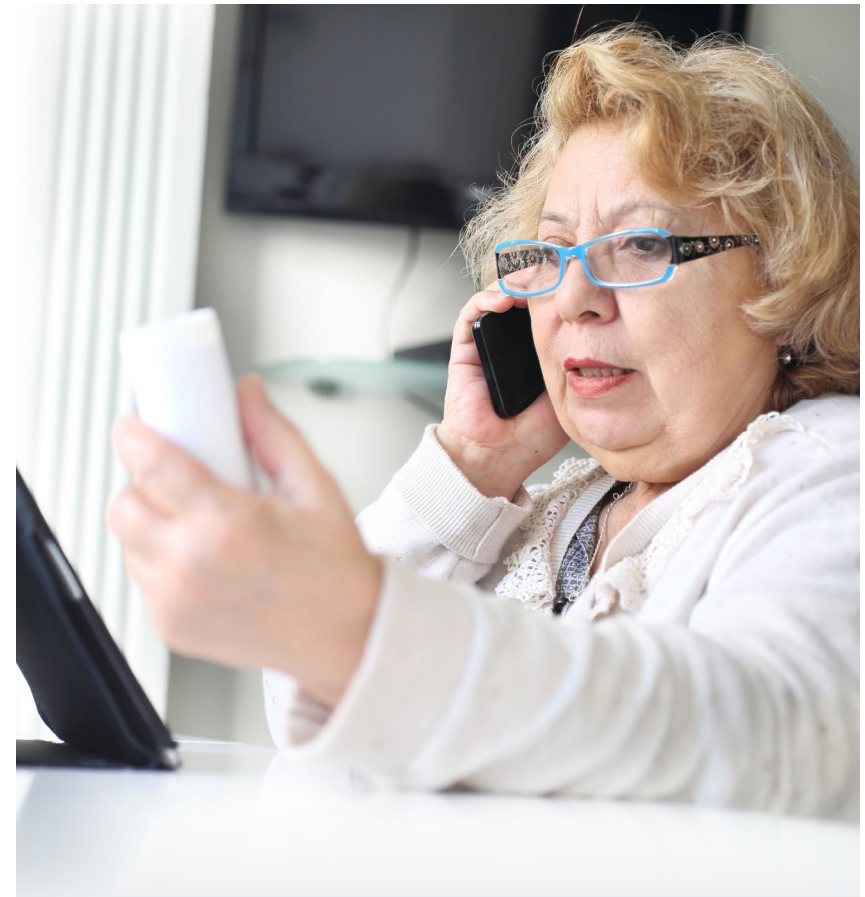
Standard referral template: Detail

The intervention (continued)

Delivery

- The final electronic version of the template reflects GPs' comments, ensuring it is an easy-to-use tool including an automatic pop-up and pre-population of appropriate fields.
- The following operational concerns arose during the 100 days:
 - Monitoring whether the form is being used by pilot practices is a labour-intensive process: it requires a manual review of all referrals from the pilot practices.
 - Some referrals from the pilot practices do not use the template.
 - The referral template is not always fully completed.

The outcome: The MSK triage service **received 155 referrals** from pilot practices over the testing period, with **more than 90% using the template**. Of those, 48% contained a completed template. As a single point of access for T&O, MSK and Pain Management the template supported the decision to redirect **23% of referrals into a more appropriate specialty**.





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Self-referral to MSK physiotherapy: Detail

The challenge

Under the current system, patients are required to see their GP for access (referral) to the MSK service. This creates additional workload for GPs, which could be avoided by opening the MSK service to self-referrals. Evidence from the Chartered Society of Physiotherapy supports the case for self-referrals, suggesting significant savings in GP workload and high patient satisfaction*.



The intervention

Scope

- Self-referral to MSK will allow patients to self-refer to the MSK service as opposed to having to see their GP first to be referred through ERS.
- The patient will book an appointment at an MSK reception desk or on the phone. Online booking options are also being explored.
- Desired self-referral waiting time is 1-2 weeks, making access to specialist care faster than the traditional route.
- The intervention is expected to reduce GPs' workload and encourage patients to take ownership of their health condition.
- Patients will still get access to primary care with MSK conditions – a GP can still refer a patient to MSK through ERS.

Planning and preparation

- The intervention requires:
 - Training of administrative staff to accept self-referred patients and book their appointments.
 - Communication with GPs informing them about the availability of the service and its implications for patients and primary care workload.
- When booking the appointment, a patient will provide their personal details. This will enable the MSK service to identify the patient on EMIS and access data required for the MSK appointment.
- Service under-staffing delayed the delivery of the intervention. However, the MSK service is currently in a recruitment phase and was due to test the intervention in Autumn 2017.

*Chartered Society of Physiotherapists (2017). 'Think physio for primary care: policy briefing England 2017' www.csp.org.uk/documents/think-physio-primary-care-policy-briefing-england-2017



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Strengthening MSK self-management support: Overview

The challenge

Patients often follow pre-defined pathways without an opportunity to discuss their treatment plans with consultants. The team in Fylde Coast looked into the concept of shared decision making and, following [NICE guidance](#) (CG117, 1.3), aimed to educate patients about their condition and introduce them to public health resources. Patients are empowered to self-manage their conditions to improve their quality of life.



The interventions

MSK Self-Management Education (Joint Venture)

- **Opportunity:** Equip patients with information and confidence to manage hip and knee osteoarthritis (OA) in the community, using self-management resources and public health services.
- **Scope:** The education session is a workshop run by a number of public health, primary and secondary care speakers. They provide attendees with information about OA and encourage them to self-manage their conditions, showing the improvements in the quality of life that self-management brings.
- **Intervention tested:** Patients diagnosed with OA who have not yet been referred to secondary care with their condition were invited to the workshop. To reinforce the de-medicalised message of the workshop, the event was held in a local sport club.
- **Results:** 60 people attended three workshops in total: based on a survey completed before and after the event, the number of attendees fully confident in managing OA increased by 89%. More than a third of attendees responded that they were extremely likely to recommend the event.





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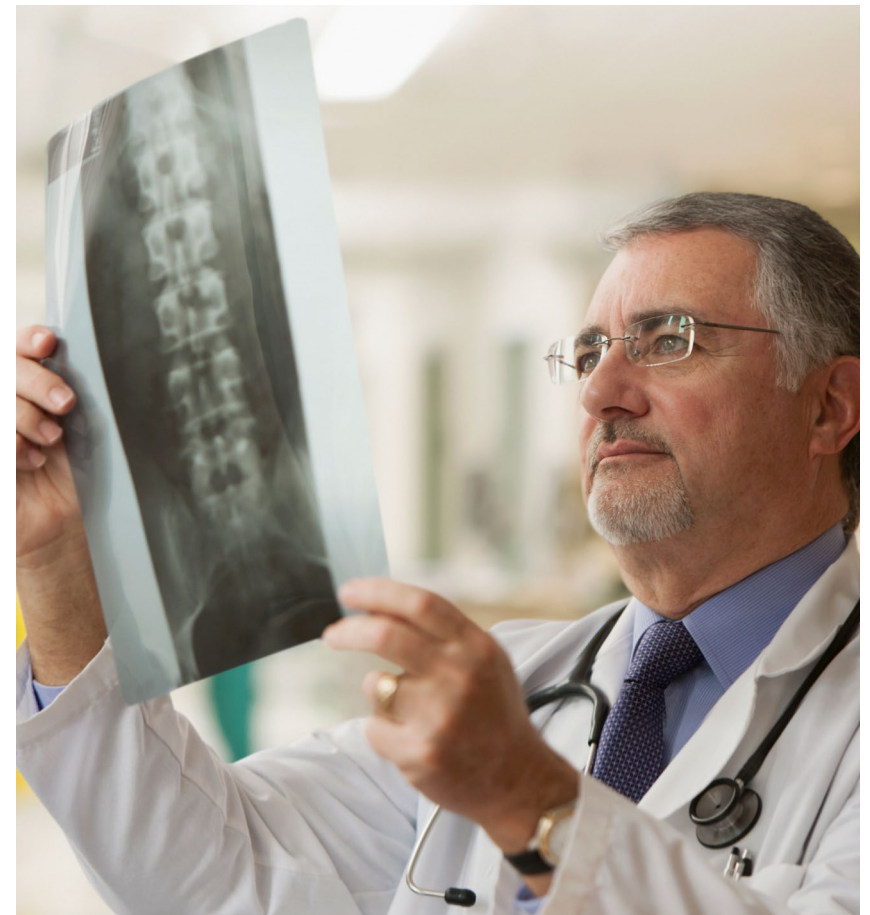
Strengthening MSK self-management support: Overview

The interventions (continued)

Patient passport (self help guide)

- **Opportunity:** Similar to the workshop, the passport equips patients with information to build their confidence in managing hip and knee osteoarthritis (OA) in the community, using self-management resources and public health services.
- **Scope:** A stand-alone booklet, the guide avoids using clinical language, consistently encouraging patients to help relieve their joint pains by means of self-checks and advice. This highlights the message of de-medicalisation and self care.
- **Intervention tested:** The passport is an A5-sized booklet and was handed out at a workshop.
- **Results:** 57 Self Help Guides were handed out at a masterclass, with 26 (46%) attendees willing to participate in the follow-up feedback. Of those, about 60% of respondents had used the guide at least once since the masterclass. Most users (71%) found the information useful and nearly a third (29%) had used the self-checks.

For further information contact: Mike Bryant,
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MSK self-management education (joint venture): Detail

The challenge

Under the current system, patients often expect a surgical solution to achieve full pain relief and full joint mobility. This leads to patients' medicalisation and demand for elective care. In cases where the surgery does not yield the results patients expected, they attend multiple follow-up appointments, trying to regain joint function and mobility that is not realistic to expect. Fylde Coast's education sessions aim to shift this expectation.



The intervention

Scope

- The multi-disciplinary education (locally called the Joint Venture) is a 90-minute workshop which helps patients with osteoarthritis (OA) to manage their condition in the community.
- Following NICE guidance, the workshop aims to prevent patients medicalisation.
- The cohort was made up of patients with GP-diagnosed OA who have not been referred to medicalised care as a result of their condition.
- The education aims to enhance patients' confidence in managing OA and demonstrates that this can lead to improved quality of life without medicalisation and a surgical pathway.
- Similar to the passport, the workshop sits in the pre-referral part of the pathway.

Planning and preparation

- The workshop includes OA-focused presentations by a number of speakers, who were identified by the team:
 - The MSK service, a pharmacist, expert patients with opposite experience of surgery, a wide range of local community services (e.g. weight control, smoking cessation, wellbeing service etc.) and an orthopaedic surgeon.
- De-medicalised venues were booked for the event (e.g. rugby club).
- Patients for the workshop were identified by four GP practices (two Fylde & Wyre CCG, two Blackpool CCG).
 - Patients were sent a written invite and asked to book their place over a dedicated phone line.



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MSK self-management education (joint venture): Detail

The intervention (continued)

Delivery

- The team ran three events, each attended by 15 to 40 people each.
- The workshop started with a market-like introduction: attendees were encouraged to visit stalls of community services, whose representatives spoke at the event.
- A questionnaire was handed out to, and collected from, attendees on the day for monitoring and evaluation purposes.

The outcome: 60 people attended the workshops: the number of attendees **fully confident in managing OA increased by 89%** (an increase from 19 to 36 people). Moreover, **over three quarters of attendees** responded that they were likely (45%) or extremely likely (38%) to **recommend the workshop**.





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Patient passport (self help guide): Detail

The challenge

Under the current system, patients often expect a surgical solution to achieve full pain relief and full joint mobility. This leads to patients' medicalisation and demand for elective care. In cases where the surgery does not yield the results they expected, patients then attend multiple follow-up appointments, trying to regain joint function and mobility that is not realistic to expect. The passport aims to shift this expectation.



The intervention

Scope

- The patient passport (locally called Self Help Guide) helps patients with osteoarthritis (OA) to manage their conditions in the community before they are referred to secondary care.
- The cohort involved patients with GP-diagnosed OA who had not yet been referred to medicalised care as a result of their condition yet.
- Adhering to [NICE guidance](#) and by means of self check exercises, the guide provides patients with the understanding and confidence to manage their OA in the community, thereby increasing their quality of life without medicalisation.

Planning and preparation

- The draft of the passport was led by an MSK consultant and MSK service support lead.
 - Local authorities also contribute, providing a list of public health services available across the CCGs' footprints.
 - Some of the self-management and self check content is inspired by online Arthritis Research UK materials.
- The draft was circulated to the wider team for comments and subsequently finalised by a smaller group of MSK consultants, a service support lead and both CCGs' representatives.
- Overall, the guide avoids using clinical language, consistently encouraging patients to help relieve their joint pains themselves. This highlights the message of de-medicalisation and self care.



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Patient passport (self help guide): Detail

The intervention (continued)

Delivery

- The guide was published as an A5-sized booklet. It is mostly handed out at patient education (see [page 17](#)) but is also intended to be shared by GPs and physios.
- A follow-up workshop questionnaire was sent to attendees about three weeks after the event. The questionnaire sought feedback on the passport, trying to understand whether attendees had used it subsequently.

The outcome: 57 Self Help Guides were handed out at a patient workshop, with 26 (46%) attendees willing to participate in the follow-up feedback. Of those, about **60% of respondents had used the Guide** at least once since the workshop. Most of the users (71%) **found the information useful** and nearly one third (29%) had used the self checks.





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Transforming opioid management: Overview

The challenge

Under the current system, patients often use opioids inappropriately (defined as use that makes no significant difference to a patient's pain condition or quality of life). The current model in which opioid initiation or escalation is not linked to an assessment of improvement in pain or quality of life, makes it less likely a patient will be taken off opioids if their pain and quality of life do not respond to the treatment.



The intervention

Opioid management

- **Opportunity:** Promote appropriate use of opioids by linking it to an assessment of the response to treatment in terms of pain and quality of life improvements.
- **Scope:** Promoting management of opioid users in primary care by collaboration of the Pain Management Service and GPs/community pharmacists, equipping the latter with resources and knowledge to provide to patients and promote appropriate use of opioids.
- **Intervention tested:** Manage first-time opioid users better through online resources, assessment of pain and quality of life, prescriber-patient contract, a patient information leaflet, and an education day for GPs/community pharmacists.
- **Results:** The intervention was due to be tested in summer 2017.

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Transforming opioid management: Detail

The intervention

Scope

- The intervention aims to encourage appropriate use of opioids in primary care. It consists of five main components:
 - **Patient information leaflet:** Encourages appropriate use of opioids in primary care.
 - **Response to treatment assessment:** Quality of life and pain levels assessed in response to opioids.
 - **Prescriber-patient contract:** Clearly sets out conditions under which an opioid is prescribed and continued.
 - **Online self care repository:** Provides patients with self care information on how to manage chronic pain and increase quality of life without opioids.
- **Education day:** Organised by the Pain Management Service for GP practices (GPs, pharmacists and/or nurses), this event will promote education in pain management.
- The intervention focuses on the group of first-time opioid users and aims to improve their management in primary care.

Planning and preparation

- A core opioid management group was set up, consisting of CCG medicine optimisation leads, a Pain Management Service consultant and a Pain Management Service nurse.
 - The core team drafted all five intervention components.

- Pilot practices were selected by CCGs on a discretionary basis: three practices in Fylde & Wyre CCG and one practice in Blackpool CCG.
 - Participating GP pharmacists commented on the core team's drafts and the components were then finalised by the group.
- As part of the contract, an EMIS template was drafted by the team that helps pharmacists capture patients' pain score and quality of life.
 - The template is based on simple quantitative scales used by the Pain Management Service.

Delivery

- The intervention has been fully scoped and was due to be delivered in summer 2017.



The outcome: The intervention was delivered in summer 2017 with the outcome evaluation expected to be available soon afterwards.



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Elective care 100 day challenge **Somerset case studies**



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Local context

The health and care system in Somerset

The Somerset system is in the South of England region of NHS England. In this programme, NHS England has worked with:

- Yeovil District Hospital FT (YDH)
- NHS Somerset Clinical Commissioning Group, covering 71 GP practices (SCCG).
- Somerset Partnership NHS Trust.

MSK pathway

The MSK pathway in Somerset includes a Tier 2 MSK service, available in the community, which encompasses an MSK and physiotherapy service.

The service acts as a single point of access for T&O and MSK. As part of the Elective Care Transformation Programme, a single standard referral template was tested for patients with hip & knee conditions in Somerset.

All primary care referrals in Somerset are made electronically, using the e-Referral System, and sent to the MSK service.

Somerset MSK rapid-testing team

The frontline team comprised the following representatives:

Administrative & clerical	Clinicians
Operational Manager – Trauma & Orthopaedics Medicine (YDH)	Consultant Orthopaedic surgeon (YDH)
Transformation Programme Manager (SCCG)	GP
Practice Manager	Physiotherapist
	Orthopaedic Assessment Senior Manager



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Improving the quality of referrals: Overview

The challenge

Referrals link a patient's journey from primary to secondary care. As the patient moves from one setting to another, it is important that referral details are transferred with the patient and in sufficient detail. It is the job of both primary and secondary care to agree what the right pathway for the patient is and what information needs to be provided. Somerset has tested a number of interventions to improve the referral process.

The interventions

Standard referral template

- **Opportunity:** To reduce inappropriate referrals coming to the specialist service and improve the quality of referral information.
- **Scope:** The template outlines referral information that the MSK service require in order to be able to provide the patient with appropriate specialist care.
- **Intervention tested:** The template was jointly drafted by a GP and consultant who sought feedback from a wider group of health professionals. It is available on EMIS with a number of fields pre-populated by the system. A GP completes the rest of the template and attaches it to a referral on ERS.
- **Results:** By day 100, all hip and knee referrals from South Somerset GPs into OASIS (MSK interface service) were made using the standard template. Initial feedback from OASIS and GPs has been positive "I think the form is a great improvement and auto completes so takes no longer than a normal referral."

GP education for X-ray requests

- **Opportunity:** Patients in South Somerset who are referred to OASIS require the right X-ray views to be conducted before they are seen at their first appointment by OASIS.
- **Scope:** The changes to the pathway included that for any patient with a knee injury, a "4 knee series view" (weight-bearing AP, weight bearing flexed PA, lateral and skyline) was taken so clinicians could fully exclude early arthritis as a diagnosis.
- **Intervention tested:** The consultant and GP jointly wrote to all South Somerset GPs setting out the change in the pathway.
- **Results:** YDH X-ray Department has changed its protocol to ensure that every knee X-ray request is "4 views".

For further information contact: Rebecca Whittaker,
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Standard referral template: Detail

The challenge

Under the current system, patients are often referred to multiple specialties, including MSK and Pain Management, sometimes with insufficient referral information. This prevents effective triage and results in a number of inappropriate referrals. As a result, it may often take several appointments at various specialties for a patient to see the right person.



The intervention

Scope

- The standard referral template is used by primary care for referrals for any hip and knee orthopaedic referrals.
- It is available on EMIS with a number of fields pre-populated by the system. A GP completes the rest of the template and attaches it to a referral on ERS.
- The template was piloted with 17 GP practices.

Planning and preparation

- The template was developed collaboratively by primary and secondary care over a number of versions and shared with three GP practices to test before sharing with a wider group of 17 practices.
- The introduction, openness to challenge and reflection of GPs' comments helped to make the template familiar to the practices.
- Pilot practices were identified by CCGs on a discretionary basis and were linked to the EMIS team which advised them on access to the template.

Delivery

- The final electronic version of the template reflects GPs' comments, ensuring it is an easy-to-use tool including an automatic pop-up and pre-population of appropriate fields.
- The form, generally, has received positive feedback from GPs. As one said: "I think the form is a great improvement and (it) auto completes so (it) takes no longer than a normal referral."
- The following emerging operational concerns arose during the 100 days:
 - Monitoring whether the form is being used by pilot practices is a labour-intensive process: it requires a manual review of all referrals from the pilot practices.
 - The referral template is not always fully completed.

The outcome: By day 100, all hip and knee referrals from South Somerset GPs into OASIS (the MSK interface service) were made using the standard template.



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GP education for X-ray requests: Detail

The challenge

Under the current system, GPs sometimes do not provide the right X-ray when they refer a patient. This leads to unnecessary appointments as further appointments are needed before a clinical decision can be made about the appropriate treatment for the patient.



The intervention

Scope

- The team wanted to add more clarity for GPs about the type of X-rays required so they could make a clinical decision on first appointment with a patient.
- The changes to the pathway included that for any patient with a knee injury a "4 knee series view" (weight-bearing AP, weight bearing flexed PA, lateral and skyline) was taken to enable clinicians to fully exclude early arthritis as a diagnosis.
- The pathway change was piloted with 17 GP practices.

Planning and preparation

- The change to the pathway was led by an orthopaedic consultant with input from GPs. It had a number of iterations and was shared with three GP practices to be tested first.
- The introduction, openness to challenge and reflection of GPs' comments helped to socialise the template with the practices.

Delivery

- The preparation ensured that when the pathway was communicated to a wider group it was well received.
- The change, generally, has received positive feedback from GPs. As one said: "It's been good to get it right first time".
- A joint letter sent out from the consultant body at YDH, GPs from OASIS East and the X-ray department to GP practices across South Somerset.
- The letter articulated the case for change and the new policy which was accepted with no pushback from GPs across South Somerset.

The outcome: YDH X-ray Department has changed its protocol to encompass that every knee X-ray request is "4 views".



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Strengthening MSK self-management support: Overview

The challenge

Patients often follow pre-defined pathways without an opportunity to discuss their treatment plans with consultants. The team in Somerset looked into the concept of shared decision making and, following [NICE guidance](#) (CG117, 1.3), aimed to educate patients about their condition and introduce them to public health resources. Patients are supported to self-manage their conditions to improve their quality of life.



The interventions

MSK self-management education

- **Opportunity:** Equip patients with information and confidence to manage hip and knee osteoarthritis (OA) in the community, using self care resources and public health services.
- **Scope:** The education is run by a number of public health and primary and secondary care speakers. They provide participants with information about OA and encourage them to self-manage their conditions, showing the improvements in the quality of life that self care brings and the wider healthcare support that is available locally.
- **Intervention tested:** Patients within one GP practice that were diagnosed with OA who have not yet been referred to secondary care were invited to the workshop.
- **Results:** Low attendance at the first workshop resulted in a rethink as to how people suitable for the session are identified.





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Strengthening MSK self-management support: Overview

The interventions (continued)

Patient passport

- **Opportunity:** As with the workshop, the passport equips patients with information to build their confidence in managing hip and knee osteoarthritis (OA) in the community, using self care resources and public health services.
- **Scope:** The guide uses minimum clinical terms, consistently encouraging patients to help their knee or hip joint pains by means of self checks and advice.
- **Intervention tested:** The passport is a stand-alone A5-sized booklet which was handed out to patients who were reviewed within OASIS with an OA diagnosis.
- **Results:** 75 passports were handed out at appointments in OASIS. A limited feedback sample reported that 50% had used the booklet and found it useful. The team will continue to share the passport to gather more feedback from patients.

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MSK self-management education: Detail

The challenge

Under the current system, patients often expect a surgical solution to achieve full pain relief and full joint mobility. This leads to patients' medicalisation and demand for elective care. In cases where the surgery does not yield the results, they attend multiple follow-up appointments, trying to regain joint function and mobility that is not realistic to expect. The knee workshop aims to shift this expectation.



The intervention

Scope

- The multi-disciplinary team workshop is a two hour education session which helps patients with osteoarthritis (OA) of hip or knee to manage their condition in the community.
- Following [NICE guidance](#), the purpose of the workshop is to empower patients to self-manage their condition in a de-medicalised way.
- The education aims to enhance patients' confidence in managing OA and demonstrates that this can lead to improved quality of life without medicalisation and a surgical pathway.
- The workshop sits in the pre-referral part of the pathway.

Planning and preparation

- The workshop includes OA-focused presentations of a number of speakers, which were identified by the team:
 - A physio, a pharmacist, a wide range of local community services (e.g. weight control, smoking cessation, wellbeing service etc.) and an orthopaedic surgeon.
- The session was held at Yeovil District Hospital.
- Patients for the workshop were identified by the team on a discretionary basis, sent an invite and asked to book their place.



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MSK self-management education: Detail

The intervention (continued)

Delivery

- The team ran one event, attended by three patients.
 - Low attendance at the first workshop resulted in a rethink as to how people suitable for the session are identified.
- The workshop started with a market-like introduction: attendees were encouraged to visit stalls of community services, whose representatives had been invited to attend and spoke at the event.
- A questionnaire was handed out to and collected from attendees on the day for monitoring and evaluation purposes.



The outcome: Initial feedback was positive. However, marketing channels and patient invitation processes require improvement to boost the number of attendees.



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Patient passport: Detail

The challenge

Under the current system, patients often expect a surgical solution to achieve full pain relief and full joint mobility. This leads to patients' medicalisation and demand for elective care. In cases where the surgery does not yield the results the patient expected, they attend multiple follow-up appointments, trying to regain joint function and mobility that is not realistic to expect. The passport aims to shift this expectation.



The intervention

Scope

- The patient passport helps patients with osteoarthritis (OA) of hip or knee to manage their conditions in the community.
- Similar to the education workshop and in line with [NICE guidance](#) and by means of self check exercises, the passport provides patients with understanding and confidence that they can manage their OA in the community, thereby increasing their quality of life without medicalisation.

Planning and preparation

- The draft of the passport was led by a physiotherapist with support from an orthopaedic consultant and GP.
- Community care services provided a list of public health services available across the South Somerset footprint.
- Some of the self care and self check content is inspired by other patient passports developed within the 100 day challenge programme (e.g. in Stockport).

- Overall, the passport uses minimum clinical terms and provides information and advice to support patients to manage their joint pain themselves.

Delivery

- The guide was published as a stand-alone A5-sized booklet. It is mainly handed out at a knee workshop (see [page 29](#)) but is also given out by GPs at OASIS clinics.
- The team used other examples of patient passports to influence their content and drew on expertise in Yeovil Hospital's communications team to help format the document.

The outcome: 75 passports were handed out at OASIS clinic appointments. Feedback from patients will be gathered after the end of the 100 days.



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Transforming outpatients: Overview

The challenge

A number of patients attend multiple outpatient appointments which require travel to hospital. The team in Somerset aimed to transform outpatient clinics to moderate and better manage demand for elective care while making the healthcare system easier and more flexible to access for the patient.



The intervention

Patient-initiated post-op follow-up

- **Opportunity:** Conduct patient-initiated post-op follow ups for patients without complications, making patient access to health care easier, more flexible and more meaningful.
- **Scope:** Patients booked for a patient-initiated follow-up (PIFU) appointment were given a specific time window to activate the follow-up if required. The intervention has been implemented across all OA conditions.
- **Intervention tested:** PIFU criteria were developed by the secondary care consultant with input from the rest of the team. All patients who meet PIFU criteria are being offered this follow-up method.
- **Results:** 796 people have been identified for a PIFU within the 100 days, all of which were offered the virtual follow-up in a letter. Of the PIFU that have already taken place, the DNA rate is 0.38%. This is 4.4% lower than those appointments that are not initiated by the patient.

For further information contact: Rebecca Whittaker,
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Patient-initiated post-op follow up: Detail

The challenge

Under the current system, patients without complications come to hospital to see a consultant for a routine follow-up. The tested intervention instead gives the patient an option to decide whether they would get much out of the appointment and encourages them to be involved in the management of their condition, avoiding unnecessary follow-up appointments.



The intervention

Scope

- In Somerset, many post-operative patients are referred to physiotherapists or hand therapists, and do not need an additional follow-up at an orthopaedic clinic.
- In line with existing schemes in Somerset the team decided to test patient-initiated follow ups (PIFU) within the shared focus on transforming outpatient appointments.
- For the purpose of the testing, the intervention was originally intended to apply to all OA post-op follow ups. However, orthopaedic consultants later developed a list of clinical exceptions for patients who should not be given the choice to initiate a follow-up.

Planning and preparation

- PIFU appointments were given for a specific time frame
- The team also developed a set list of clinical criteria for “exceptions”, where patients should not receive the option for an initiated follow-up.

- Originally aimed at post-op follow ups for elective patients, the pilot focused on fracture post-op follow ups for resourcing reasons.

Delivery

- Patients suitable for a PIFU were first identified by a service manager on the basis of their condition (to see if they met the consultant-designed criteria for a PIFU).
- Their case notes were subsequently reviewed by a consultant who made the final decision about the suitability of a patient-initiated follow-up for the patient.

The outcome: 796 people have been identified for a PIFU within the 100 days, all of which were offered the virtual follow-up in a letter. Of the PIFU that have already taken place, the DNA rate is 0.38% which is 4.4% lower than those appointment that are not initiated by the patient.



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Local context

The health and care system in Stockport

The Stockport system is in the North of England region of NHS England.

As part of Stockport Together, a vanguard programme aimed at transforming patient care, five health and care organisations work together to serve the needs of people living in Stockport. They are: NHS Stockport Clinical Commissioning Group (with 41 GP practices), Pennine Care NHS Foundation Trust, Stockport Metropolitan Borough Council, Stockport NHS Foundation Trust (SNHSFT) and Viaduct Care (a federation representing all Stockport GPs).

MSK pathway

The MSK service in Stockport can be accessed through various pathways. GPs can refer via Choose and Book to:

- Tier 2 community-based Orthopaedic triage.
 - Referrals are electronically triaged by an external organisation and either triaged to:
 - Stockport FT community-based Tier 2 Orthopaedic assessment service (OAS) or
 - Directly to secondary care.
 - Following a face-to-face assessment in the Tier 2 service, patients can be referred into any NHS MSK services in Stockport (incl. rheumatology, pain management and neurology).
- Directly to secondary care into any speciality.

Stockport MSK rapid-testing team

The frontline team comprised the following representatives:

Administrative & clerical	Clinicians
Head of Service Reform, Stockport CCG	Consultant Orthopaedic Surgeon, SNHSFT
General Manager, SNHSFT	Pre-op Nurse, SNHSFT
Voluntary Sector Organisation Lead	Orthopaedic Assessment Service Team Leader
Administrator, Stockport CCG	Extended Scope Practitioner
	Pharmacist
	GP



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Strengthening MSK self-management support: Overview

The challenge

Stockport's orthopaedics service have been seeing a high number of patients who could benefit from self-management support. The team therefore looked into the concept of shared decision making and, following [NICE guidance](#) (CG117, 1.3), aimed to educate patients about their condition and introduce them to public health resources. This supports patients to self-manage their conditions to improve their quality of life.



The interventions

MSK self-management education

- **Opportunity:** Equip patients with information and confidence to manage knee osteoarthritis (OA) independently, using self-management resources and public health services.
- **Scope:** People over the age of 50 diagnosed with knee OA who have not yet been referred to secondary care.
- **Intervention tested:** The 90-minute workshop is run by a number of public health and primary and secondary care speakers. They provide participants with information about OA and encourage them to self-manage their condition, demonstrating the improvements in the quality of life that self-management brings.
- **Results:** Three workshops were piloted, with more than 100 participants. From the 83 feedback questionnaires received, the event increased the number of patients who felt very confident managing their OA by more than 650% (increase from 8 to 61 patients). About 90% of participants responded that they were likely or extremely likely to recommend the event.



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Strengthening MSK self-management support: Overview

The interventions (continued)

Patient passport

- **Opportunity:** The passport equips patients with information to build their confidence in managing knee OA independently and in using self-management resources and public health services.
- **Scope:** Patients diagnosed with knee OA across Stockport. The booklet was handed out at patient knee workshops and distributed by the local orthopaedic assessment service, GPs and physios.
- **Intervention tested:** A stand-alone booklet, the passport informs patients about their condition, local support available and actions that they can take to self-manage their condition. The guide also includes fields where patients can set their own health goals and measure their progress towards them, to be used as a shared decision making tool.
- **Results:** Over 100 passports were handed out at knee workshops during the 100 day challenge. Limited early feedback has been positive. The team is awaiting further feedback.



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MSK self-management education: Detail

The challenge

Stockport's orthopaedics service reported that they were seeing a high number of patients who could benefit from self-management support. Following [NICE guidance](#), the 100 day challenge team introduced local knee workshops to help educate and empower patients to self-manage their condition, promote early intervention and support shared decision-making about treatment options.



The intervention

Scope

- 90-minute education workshops supporting self-management (in line with [NICE guidance](#)) of patients with knee osteoarthritis (OA) who have not yet been referred to secondary care.
- The workshops included information on:
 - What OA is, its causes and myth busting.
 - Conservative management (physio and exercise).
 - Pain management (pharmacology remedies).
 - Surgical options, risks and benefits.
 - Expert patients' experiences of surgery/treatment.
- They also featured stands run by local community organisations, highlighting support available locally.

Planning and preparation

- The workshops were delivered by a multi-disciplinary team including a GP, pharmacist, pre-op nurse, physios and allied health and social care organisations.
- The local orthopaedic service and GP practices referred patients (50+ years of age) to the workshop and the event was also advertised in the community for self-referral – including in libraries, pharmacies, golf and leisure clubs and GP practices.



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MSK self-management education: Detail

The challenge

Stockport's orthopaedics service reported that they were seeing a high number of patients who could benefit from self-management support. Following [NICE guidance](#), the 100 day challenge team introduced local knee workshops to help educate and empower patients to self-manage their condition, promote early intervention and support shared decision-making about treatment options.



The intervention (continued)

Delivery

- The team ran three events, each attended by 30 to 40 people each, which lasted approximately 90 minutes.
- Over half (57%) of attendees at the final workshop were self-referred.
- The workshops started with a registration and weigh-in, where attendees' BMI was calculated and they were given a patient passport in which to record this information.
- Patients were encouraged to visit stands run by community organisations before the session, heard talks from health professionals and representatives from different services, and had the opportunity to ask questions.
- Participants were asked to fill out an evaluation questionnaire to indicate whether their knowledge of, and confidence in, self-managing their condition had increased as a result of the session.

The outcome: Of 83 feedback questionnaires collected, the event increased the number of patients who felt very confident managing their OA by more than 650% (increase from 8 to 61 patients). About 90% attendees responded that they were likely or extremely likely to recommend the event.



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Patient passport: Detail

The challenge

Stockport's orthopaedics service reported that they were seeing a high number of patients who could benefit from self-management support. Following [NICE guidance](#), the 100 day challenge team created a 'patient passport' that aims to educate and empower patients to self-manage their condition and support shared decision-making about their care.



The intervention

Scope

- The patient passport is a short booklet that helps patients with osteoarthritis (OA) of the knee to self-manage their condition independently (adhering to [NICE guidance](#)).
- The passport includes:
 - Information about OA and its causes.
 - Fields where patients can record their medical information and appointments with health professionals.
 - Links to local health and social care support services and resources.
 - Charts where patients can set personal health targets and measure their progress towards them.
 - Information on self-management techniques and fields where patients can record different treatments that they have tried.

- Patients are encouraged to take their passports with them to health appointments and use them in other instances, such as visits to the pharmacy, so that professionals are aware of what steps patients have already taken to self-manage their condition and to support shared decision-making.

Planning and preparation

- The passport was co-drafted by a multidisciplinary team including members of the local orthopaedic assessment service, a GP, a pharmacist and voluntary sector organisations.
- It avoids use of clinical language, highlighting the principles of self care



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Patient passport: Detail

The intervention (continued)

Delivery

- The passport was published as an A5-sized booklet. It is distributed in knee workshops, and by GPs and physios.
- A follow-up questionnaire was sent to attendees of the knee workshops three weeks after the event. The questionnaire sought feedback on the passport, including whether attendees had used it subsequently.

The outcome: Over 100 passports were distributed as part of knee workshops during the 100 day challenge. Early feedback (from eight users) has been positive. The team is awaiting further feedback.





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Transforming outpatients: Overview

The challenge

Stockport's orthopaedics service were facing long clinic waiting times and were keen to utilise their clinic time more effectively. In an effort to do things differently and provide more convenient care for patients, the team introduced telephone follow up appointments for hip, knee, shoulder and hand clinic patients.



The intervention

Telephone follow ups

- **Opportunity:** Conduct post-intervention or post-diagnostic follow ups for appropriate patients without complications via telephone, making patient access to care easier and more flexible.
- **Scope:** For the purpose of the testing, the intervention was applied to hip, knee, hand and shoulder clinic follow ups at Stockport NHS Foundation Trust.
- **Intervention tested:** Extended scope practitioners and specialist nurses deliver the telephone follow ups. The patient only proceeds to a face-to-face appointment if a physical examination is deemed necessary by the clinician.
- **Results:** 97% of 58 telephone follow ups did not require a face-to-face appointment. Of the total of 69 telephone follow ups offered, the DNA/UTA* rate stood at 16%. Of the appointments held, 34% of patients were discharged following their telephone follow-up and a further 47% were listed/referred for another procedure/investigation, thereby avoiding an unnecessary face-to-face appointment.

*Did not attend/unable to attend

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Telephone follow ups for orthopaedics: Detail

The challenge

Stockport's orthopaedics service were facing high clinic waiting times and were keen to use their clinic time more effectively. In an effort to do things differently and provide more convenient care for patients, the team introduced telephone follow up appointments for hip, knee, shoulder and hand clinic patients.



The intervention

Scope

- Telephone follow ups aim to limit the time spent on routine post-intervention or post-diagnostics follow ups and eliminate the need for patients to come to hospital.
- The patient proceeds to a face-to-face appointment if a physical examination is required.
- For the purpose of the pilot, the intervention was applied to all hip, knee, shoulder and hand follow ups, with the aim of creating a virtual fracture clinic in the future.

Planning and preparation

- The service manager at the local hospital got buy-in from all local orthopaedic specialists in the hospital to shift to a telephone follow-up model, to help reduce clinic waiting times and provide greater convenience for patients.
- The service manager looked at existing clinic lists and used this to select the specialties that the service would focus on. In addition, ESPs reviewed clinic lists to identify suitable patients who were already booked into face-to-face clinic appointments and rescheduled them for a telephone review instead.
- Initially the process was time consuming, as clinicians had to contact patients to explain why they were rescheduling to a telephone appointment instead. However, moving forwards this will not be necessary as clinics should naturally fill up with direct requests from orthopaedic specialists.



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Telephone follow ups for orthopaedics: Detail

The intervention (continued)

Delivery

- Specialist nurses and ESPs run weekly telephone clinics.
- The telephone follow up processes are similar to face-to-face follow ups:
 - Send out the feedback form within a week of the appointment.
 - Patients receive a letter noting the time of their appointment.
 - The same rules apply regarding cancellations and DNAs.
 - Staff complete RTT forms for each telephone review and each consultation generates a dictation and clinic letter.

The outcome: 97% of 58 telephone follow ups did not require a face-to-face appointment. 34% of patients were discharged following the telephone appointment and further a 47% were listed/referred for another procedure/investigation, thereby avoiding an unnecessary face-to-face appointment.





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Referral interventions from primary to specialist care: a systematic review of international evidence

The intervention

Opportunity: Manage the referrals of patients to secondary care and ensure that the right patient receives the right care at the right time.

Scope: A systematic study that looked at evidence from 140 studies across the world (UK, US, Canada, Europe, Hong Kong and China) from interventions that affected referrals from primary to specialist care.

All outcomes relating to referrals were considered including: referral rate, referral quality, appropriateness of referral, impact on existing service provision, costs, mortality and morbidity outcomes, length of stay in hospital, safety, effectiveness, patient satisfaction, patient experience, and process measures (such as referral variation and conversion rates).

Intervention: The studies looked at interventions that aimed to influence and/or affect referral from primary care to specialist services by having an impact on the referral practices of the primary physicians.

Results: *GP Education – interventions focussed on GP education or training*

- GP peer review and feedback had positive effects on referrals, expenditure and quality of the referral letter.

Process changes – changing small elements of the referral process e.g. contact between GP and consultant

- Electronic referrals resulted in appropriate referral, GP satisfaction, reduction in DNA and waiting times, and better transfer of information.
- Specialist consultation before referral reduced the number of referrals, and time to treatment, while improving accuracy of diagnosis and patient evaluation of services.

System changes – changing large elements of the referral process e.g. outreach clinics

- The community provision of specialist services by GPs (previously trained by specialists), outreach or community provision by specialists, and the return of inappropriate referrals show the strongest positive effect on referral outcomes.

Reference: Blank L, Baxter S, Buckley Woods H, Goyder E, Lee A et al.(2014) Referral interventions from primary to specialist care: a systematic review of international evidence, Br J Gen Pract; 64 (629) bjgp.org/content/64/629/e765



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The development of MSK triage Services

NHS Ashford CCG, Commissioning for Value

Opportunity: Secondary care providers of orthopaedic services in East Kent were failing to meet the 18- week referral to treatment target and the CCG adopted the [NHS RightCare Methodology](#): (Where to look; What to change; How to change). They introduced a new service model whose purpose was to:

- Understand the best orthopaedic pathways for patients.
- Provide specialist advice and guidance to GPs.
- Improve the quality of referrals.
- Identify the true need for orthopaedic services to inform development of an optimal service model.
- Support the delivery of 18 weeks for orthopaedics.

Scope: A locally-designed and managed GP triage approach for all new referrals to secondary care to reduce waiting times and ensure patients get the best care.

Intervention: The triage service was delivered by a local GP consortium (Ashford Clinical Providers) whose GPs had specific experience and expertise in musculoskeletal disorder. All primary care referrals to secondary care were initially sent to the triage service using an internal electronic system and the patient was contacted within 48 hours.

Results: Since implementation of the triage service in December 2014, referral levels to secondary care from Ashford remain 40% lower than during the pre-triage peak period and slightly lower than the 13/14 baseline.





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Self-referral to MSK practitioner services

The challenge

GP referrals to MSK require patients to attend a GP appointment first before being put on a waiting list to see the specialists. Enabling people to self-refer to first contact MSK practitioner (FCP) services can speed up access to treatment, reduce GP workload and reduce inappropriate referrals to secondary care. Patients can either refer themselves directly into existing FCP services or see an FCP based in general practice.



First Contact Practitioner services: West Cheshire

Scope

- FCP physiotherapists in general practice.
- GP physio pilot for 36 practices, now expanded to evening appointments.
- The capacity of the service stands at 11,000 patients per year, which is 25% of total GPs' MSK caseload.
 - There is a scope to increase the capacity of the service further.



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Self-referral to MSK practitioner services

First Contact Practitioner services: West Cheshire

Outcome

- More than 60% of self-referred patients discharged after the first appointment.
 - Quick access to advice provides rapid return to function, no need for further treatment.
- Less than 3% of self-referred patients needed to see the GP for reasons such as medication reviews or non-MSK conditions.
- High satisfaction with the service:
 - High patient satisfaction: 99% rated service good or excellent and happy to use again (of the total of 1897 patients).
 - High GP satisfaction – 91% rated service 8+ for how beneficial service is to their practice with 45% scoring it 10/10.
- 20% fewer referrals to MSK physio services (after five years of an annual 12% increase), resulting in a reduction in waiting times.
- Savings:
 - 84% patients would have seen the GP: saving £540k a year.
 - 4% less MSK imaging: saving £11,495 a year.
 - 5.9% fewer X-rays: saving £28k a year.
 - 2% fewer orthopaedic referrals: saving £70k a year.
- The service was developed with an already successful clinical triage assessment and treatment service: in areas without the service (e.g. Darlington, see [page 51](#)) higher savings are achieved from reducing referrals.





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Self-referral to MSK practitioner services

First Contact Practitioner services

Darlington

Scope

- Intervention started in December 2015.
- Four GP surgeries involved.

Outcome

- By end of September 2016, GP physios had seen 1,147 patients.
 - Only 2% of these needed to see the GP.
 - 74% patients discharged to self-manage.
- Consultant-to-consultant referrals reduced by 18%: saving £26k in 7 months.
- High patient satisfaction:
 - 100% would recommend and use again.
 - 96% rated advice 8 or more out of 10.
 - 93% rated outcome of visit 8 or more out of 10.

Nottingham

Scope

- 12 month pilot.
- Two GP practices involved.

Outcome

- 555 patients seen by two GP physios, providing two half days each week.
- 54% discharged after the first appointment (71% discharged after the first or second appointment).
- 27% referred to physiotherapy in secondary care.
- 2% referred to the GP.
- 3% referred for diagnostics.
- 1% referred to orthopaedics (compared to 12% referral rate by the GPs before the pilot): savings of £3,085 per patient.
- 70% patients reported continuous improvement at six months.
- 80% of 350 patients across 2 sites satisfied with:
 - The service, information provided, confidence in practitioners.





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Virtual Clinics

Intervention

Brighton and Sussex University Hospital NHS virtual fracture

Opportunity: Speed up patient access to orthopaedic services and reduce unnecessary outpatient follow ups.

Scope: A patient focused alternative to traditional fracture clinics.

Intervention: Referrals reviewed by an orthopaedic consultant the next working day after presentation.

Results:

- Fewer patients are being seen in clinic as patients are discharged following a telephone and radiology review, with injury-specific advice.
- Reported a reduction of outpatient appointments- 57% since launch in August 2013.
- Increased patient understanding about their rehabilitation.

Royal Berkshire Hospital NHS Trust virtual fracture clinic

Opportunity: Speed up patient access to orthopaedic services as fracture clinics were overbooked, with long waits to be seen on the day, leading to poor patient experiences.

Scope: Fracture clinic patients and minor injuries unit patients.

Intervention: Patients are first referred to the virtual fracture clinic where patient X-ray(s) and initial assessment documentation are reviewed by an orthopaedic consultant. A trained, experienced orthopaedic nurse contacts the patient by telephone after the assessment to discuss treatment. This might consist of purely advice and discussion or may require the arrangement of an appointment at the most appropriate clinic.

Results: Increased patient satisfaction, reduction in inappropriate face-to-face outpatient outpatients, reduced waiting time.



Useful further links:

National Institute for Health and Care Excellence (2016) Fractures (non complex): assessment and management, NG38
www.nice.org.uk/guidance

www.nice.org.uk/about/what-we-do/research-and-development/research-recommendations/ng38/2



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Selected further elective care case studies

NHS England's [Demand Management Good Practice Guide](#) supports commissioners and providers to effectively manage demand for services, and includes innovative examples from across the country. This table highlights selected examples from the guide.

Theme	Case study	Abstract	Page in guide
Peer review of referrals	Integrated Care Gateway, Manchester	The development of a single referral form for assessment and peer-review by other GPs. Though this is not intended to be a permanent part of their infrastructure, it is catalysing behaviour change and learning that would enable GPs to make better decisions.	13
Advice and guidance ¹	Cambridgeshire & Peterborough CCG	105 GP practices and 4 Providers use the functionality built into ERS to review the appropriateness of referrals leading to a reduction in the rejection of referrals.	19-20
Shared decision making	MAGIC, Newcastle & Cardiff	The MAGIC (Making Good Decisions in Collaboration) programme was carried out in sites across Newcastle and Cardiff to embed best practice in shared decision making. Initiatives included the development of option grids (one page evidence-based decision aids) and "ask three questions" to encourage patients to take an active part in shared decision making.	14-16
Alternatives to outpatient appointments	Virtual Clinics	A selection of case studies covering Trafford's virtual elective orthopaedic follow up care, diabetes appointments via webcam, renal e-clinics in Tower Hamlets and literature reviews of existing evidence.	21-23

¹ Advice & Guidance is now supported by a national [CQUIN](#) and also the improved functionality of ERS.



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Quality improvement

NHS England's Elective Care programme has been working with the innovation charity Nesta and frontline teams to rapidly test quality improvement interventions over a 100 day period. The key elements of this approach are:

- 'Unreasonable' 100 day goals set by each front line team.
- A focus on action, experimentation and learning, with team members from across the system.
- Support from leaders across the system, to give permission to innovate and help teams unblock problems.

Find out more about the 100 days methodology on Nesta's website: www.nesta.org.uk/project/people-powered-results

The 100 days approach is one of a number of quality improvement techniques. The Health Foundation offers a broad range of free quality improvement tools and resources: www.health.org.uk/collection/improvement-projects-tools-and-resources.

Patient organisations

- The Arthritis and Musculoskeletal Alliance (ARMA): arma.uk.net.
- Escape Pain programme: www.escape-pain.org.
- Arthritis Research UK: www.arthritisresearchuk.org.
- Arthritis Care: www.arthritiscare.org.uk.

National policy drivers and resources

- [Next Steps on the Five Year Forward View](#): sets out key service improvement priorities for the NHS in England.
- [NHS Operational Planning and Contracting Guidance 2017-19](#): reaffirms national priorities and sets out the financial and business rules for 2017/18 and 2018/19.
- [Referral to treatment](#): rules, guidance and information on maximum waiting times under the NHS Constitution.
- [NHS Right Care](#): supporting local systems to understand their performance and implement optimal care pathways.
- [GP Forward View](#): sets out a detailed, costed package of investment and reform for primary care through to 2020, including improving access to specialist advice and guidance.
- [CCG Improvement and Assessment Framework](#): enables local health systems to assess their own progress against key metrics from ratings published online, including patients waiting 18 weeks or less from referral to hospital treatment.

Selected national guidance and advice: MSK and Orthopaedics

- [NICE recommendations](#) on patient education and self-management (CG117, Chapter 1.3).
- Monitor, British Orthopaedic Association, The Royal College of Ophthalmologists: "Helping NHS providers improve productivity in elective care", available at www.gov.uk/government/uploads/system/uploads/attachment_data/file/466895/Elective_care_main_document_final.pdf.