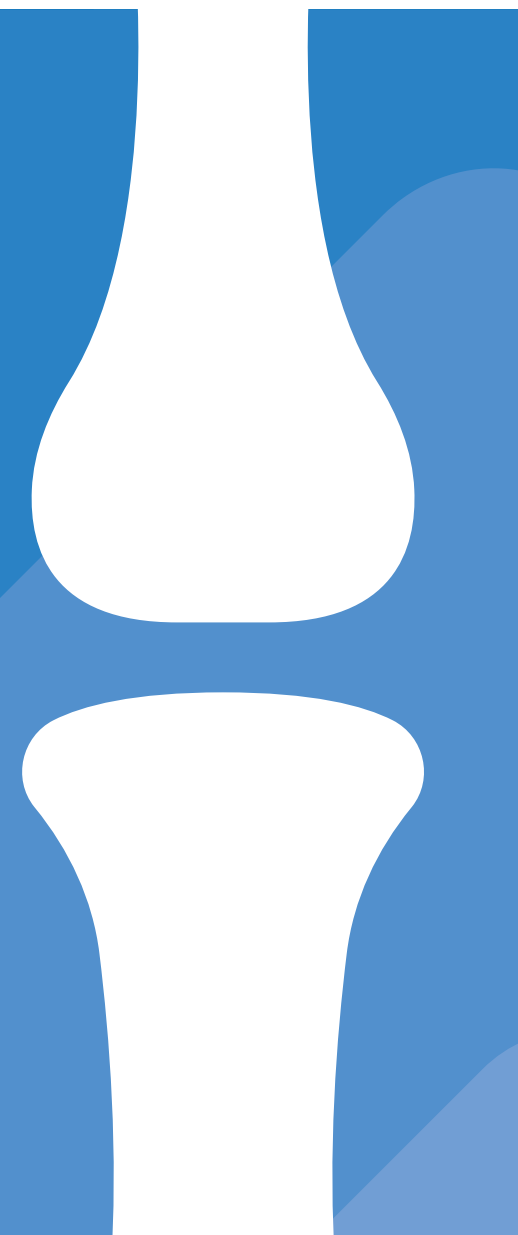**Right person, right place, first time**

Transforming **musculoskeletal and orthopaedic** elective care services

A handbook for local health and care systems

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Finance		

Publications Gateway Reference:	07424
Document Purpose	Resources
Document Name	Transforming musculoskeletal and orthopaedic elective care services
Author	Elective Care Transformation NHS England
Publication Date	November 2017
Target Audience	CCG Clinical Leaders, Care Trust CEs, Foundation Trust CEs, Medical Directors, NHS Trust Board Chairs, NHS England Regional Directors, NHS England Directors of Commissioning Operations, Allied Health Professionals, GPs, Emergency Care Leeds
Additional Circulation List	CCG Accountable Officers, CSU Managing Directors, Directors of PH, Directors of Nursing, Communications Leeds
Description	
Cross Reference (if applicable)	N/A
Superseded Docs	N/A
Action Required (if applicable)	N/A
Timing/Deadlines (if applicable)	N/A
Contact details for further information	Elective Care Transformation programme Operations and Information Quarry House LS2 7UE
Document Status	
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Contents

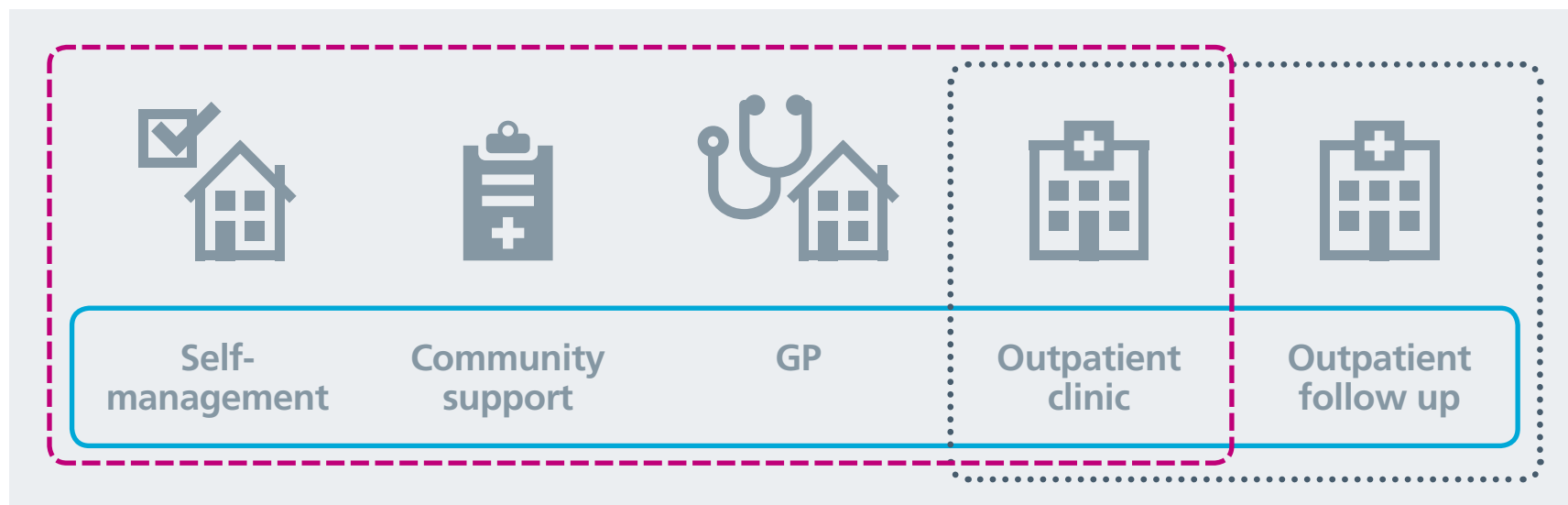**Right person, right place, first time**

Elective Care Transformation: What is it?

Elective Care Transformation means the 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 directed to the right person, in the right place, first time.

This handbook for the transformation of musculoskeletal elective care services is part of a suite of resources produced by NHS England's Elective Care Transformation programme and aims to support local health and care systems 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.

The success of interventions designed to transform local elective care services should be measured by changes in local activity following implementation of the intervention and performance against the Referral to Treatment (RTT) standard, along with patient and professional outcome and satisfaction measures. More detailed information and suggested metrics are included as part of each intervention in this handbook.

Self-management   Community support   GP   Outpatient clinic   Outpatient follow up

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Essential actions for successful transformation

The actions below are collated from the work of the Elective Care Development Collaborative. These actions are essential to creating the culture of change that is necessary as a basis for the effective implementation of the interventions outlined in this handbook.

Setup:

☐ Ensure strong support from executive level leaders across the system, to give permission to frontline staff to innovate, help unblock problems and feed learning and insight back into the system.

☐ Identify a cross-system team with sufficient protected time to lead implementation.

☐ Identify and engage all key local stakeholders (including patients, GPs and other clinicians, managers, primary and secondary care, voluntary and community sector) from the beginning and encourage them to partake.

☐ With stakeholders, identify and understand local issues and challenges, using these to identify, analyse and agree possible solutions, baseline and metrics for each theme.

Infrastructure and workforce:

☐ Seek expert advice on infrastructure (e.g. IT and telephone needs) as soon as possible.

☐ Identify staffing and skills needs as early as possible and secure this resource, as appropriate.

Engagement:

☐ Schedule regular communication and continue to engage with key local stakeholders across public health, general practice and secondary care around the proposed approach.

☐ Engage with appropriate GP representatives and use local communication networks to ensure wide patient and clinical engagement including GPs and GP representatives (eg Local Medical Committees).

Further resources to support creating the correct climate for successful large scale transformation can be found in Leading Large Scale Change: A practical guide produced by the NHS England Sustainable Improvement and Horizons Teams.

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Transforming MSK and Orthopaedic Elective Care: The Challenge

There is a clear need to re-design elective care services.

Since 2005/6 total outpatient appointments have nearly doubled from 60.6m to 118.6m. Some 418,000 patients were waiting longer than the 18 week standard for hospital treatment in September 2017 – a 20% increase on the previous year. The steady rise in referrals has contributed to that increase.

There is also unwarranted variation in activity and outcomes across England, as shown by RightCare.

Timely access to high quality elective care is a key priority, as set out in the NHS Constitution. Therefore, the Next Steps on the Five Year Forward View and the NHS Operational Planning and Contracting Guidance 2017-19 set out the redesign of services to better manage demand and increase value from investment as a 'must do' for every local system.

NHS England's Elective Care Transformation Programme supports health and care systems to reform and modernise elective care pathways. As part of this programme, the Elective Care Development Collaborative has been established to support rapid change led by frontline teams, to develop, test and spread innovation in delivering elective care services.

Through this community of practice, local systems came together using the '100 day challenge' methodology from innovation charity, Nesta. This empowers frontline leaders, clinicians and patients to design and test innovative ways of transforming elective care services across professional boundaries.

Find out more about the 100 Day Challenge methodology: www.nesta.org.uk/people-powered-results

Frontline services were challenged to develop solutions under three broad themes within the 100 days. These themes and relevant interventions from the Wave 1 sites are reflected throughout the handbook, along with further information and case studies from other sources. The themes are as follows:

Rethinking referrals
Improving the quality of referrals through advice and guidance, standardised pathways and referral templates

Maximising shared decision making and self-management support:
Improving access to self-management support and education for people with long term conditions

Transforming outpatients
Offering patient-initiated, rapid access and virtual follow ups to better meet people's needs and improve access to timely care

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Transforming MSK and Orthopaedic Elective Care: The Ask

This handbook describes what local health and care systems can do to transform MSK and orthopaedic elective care services at pace, why this is necessary and how the impact can be measured.

This handbook is for commissioners, providers and those leading the local transformation of musculoskeletal and orthopaedic elective care services. A powerful lesson from the 100 day testing process was the clear benefit of bringing together a range of clinicians, patient groups and managers from GP practices and hospitals. They demonstrated that GPs, consultants, nurses, allied health professionals, managers and patients working together can develop new pathways that improve care, reduce waiting times and maximise the efficient use of NHS resources.

Included within this handbook are selected interventions and case studies from the Elective Care Development Collaborative Wave 1 test sites alongside further case studies. The interventions are grouped into the three key themes:

Rethinking referrals

1. Advice and guidance
2. Standard referral pathways with structured templates

Maximising shared decision making and self-management support:

3. Self-management education for long term conditions

Transforming outpatients

4. Patient-initiated, rapid access and virtual follow ups

The interventions and case studies are grouped by theme within this handbook. 'How-to' guides and case studies are included to illustrate the possibilities for transformation, along with suggested metrics. The list of interventions is not exhaustive and reflects the interventions tested as part of the 100 Day Challenge in Wave 1 of the Elective Care Development Collaborative, along with further relevant information drawn from other sources.

Comprehensive guidance on redesign of gastroenterology services is not provided and emergency care or elective surgery are not covered. However, signposts to further quality improvement resources are included.

Commissioners are asked to lead local system wide transformation of elective care services, focussing on one or more of the key themes. Interventions will make most difference when implemented as part of a package of transformation, rather than in isolation.

This handbook is one of the resources produced by NHS England's Elective Care Transformation Programme and should be used alongside NHS England's directory of elective care case studies, which describe how local systems have successfully devised and implemented these interventions, along with further details about their learning throughout the transformation process.

For any queries regarding this handbook or any of the interventions or case studies, please email: england. electivecare@nhs.net

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Transforming MSK and Orthopaedic Elective Care: The Benefits

Elective Care Transformation means transforming 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.

Suggested benefits of interventions across musculoskeletal and orthopaedic elective care pathways in each of the three themes are listed below:

Rethinking referral models

- Increase access to care
- Reduce waiting times
- Reduce unnecessary or inappropriate referrals
- Improve identification of appropriate patients for referral
- Reduce secondary care follow ups
- Support patient management in primary care
- Enable effective management in the community
- Improve patient experience
- Improve patient outcomes

Maximising shared decision making and self-management

- Increase the quality and amount of information available to patients and practitioners
- Improve communication
- Improve monitoring of health status
- Increase patient access to digital self-management material
- Increase patients' understanding of their condition
- Increase patients' ability to self-manage

Transforming outpatients

- Improve access to care
- Offer telephone follow up to patients without complications
- Offer more flexible options for follow up
- Improve data quality
- Support patient management in primary care
- Enable effective management in the community
- Improve patient experience
- Improve patient outcomes

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1. MSK Clinical Review and Triage

What is MSK clinical review and triage?

MSK triage services provide a single point of access for local MSK referrals. They provide specialist clinical review of incoming referrals and triage patients to the most appropriate setting for further treatment and/or diagnosis.

Why implement clinical review and triage?

Many CCGs are ensuring MSK triage services are put in place during 2017/18, with clear referral criteria that are communicated to all GPs. The aim of MSK clinical review and triage services is, to **avoid inappropriate referrals**, **improve the quality of referrals** and **ensure that people with musculoskeletal problems are directed to the right care setting, first time**. MSK conditions affect approximately 9.6 million adults in the UK. MSK clinical review and triage services reduce demand on local secondary care services and have the potential to reduce referrals by 20-30% (equivalent to 2-3% of all GP referrals).

Implementation - how to achieve success:

☐ **Establish a cross-system implementation team** that includes all stakeholders such as orthopaedic consultants, MSK service, Rheumatology multidisciplinary team, GPs, patients, practice manager, CCG leads, physiotherapists and other allied health and wellbeing professionals.

☐ **Engage and communicate regularly with key stakeholders (in addition to the cross-system implementation team), throughout the implementation process.** Key stakeholders include consultants in orthopaedics, GPs, physiotherapists and other allied health professionals, nurses, chiropractors, osteopaths, diagnostic services, managers, patient representatives and if relevant rheumatology and pain specialists. Use CCG communication networks such as newsletters and GP events to build awareness and uptake among GPs; sharing positive feedback can be powerful.

☐ **Agree outcome measures** to evaluate the impact of the clinical review and triage service (e.g. feedback from referrers, number of referrals received and patient satisfaction measures). Ensure sufficient administrative support resources for evaluation.

Opportunities for improvement: Rethinking referrals

1. MSK Clinical Review and Triage

How to achieve success (continued):

☐ **Gather an evidence base with Data Protection Act compliant dataset.** Ascertain the number of patients referred to and discharged from secondary care for a musculoskeletal opinion, the average wait for rheumatology and orthopaedic services, and the conversion rate for orthopaedic surgery (i.e. the percentage of patients attending outpatients who are added to the waiting list).

☐ **Agree the service scope.** Work with key stakeholders to agree what will and will not be within the scope of the triage service i.e. exclusion of red flag conditions. Options proposed by test sites include surgical referrals for T&O, MSK, Pain Management and Rheumatology (or a subset of these) referrals.

☐ **Review** the standardised refferal template along with evidence-based guidance and recommendations. Work with lead clinicians from primary, secondary and community care to tailor it to local needs. If you would like a copy of a standard referral template please email england.electivecare@nhs.net.

☐ **Seek IT advice and support as early as possible** to ensure referral forms can be uploaded to GP clinical systems and adjustments to improve usability can be made (such as automatic pop-up and pre-population of patient details).

☐ **Develop referral pathways for relevant services.** Engage all key stakeholders that will make and receive referrals such as GPs and secondary care specialists.

☐ **Agree clinical guidelines and protocols** (including exclusions), along with the clinical audit framework and schedules.

☐ **Seek feedback throughout the process from stakeholders** (e.g. from local medical committees and patient user forums) and act on their comments. Consider rapid pilots of the template in selected practices to test usability.

☐ **Communicate the final pathway and template to stakeholders** using a range of methods such as email, newsletter, practice meetings and host education sessions. Include a point of contact for referrers who may require support using the form.

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Opportunities for improvement: Rethinking referrals

1. MSK Clinical Review and Triage

Measuring impact

The table below includes some of the metrics devised by the sites in Wave 1 of the Elective Care Development Collaborative as part of their logic modelling, along with additional suggestions. It is not an exhaustive list, but serves as a starting point.

Suggested metrics to measure success (this list is not exhaustive)		
Input • Associated setup costs (£) • Associated ongoing costs (£) to run the service Number of hours to: • Set up service • Develop template	**Output** Number of: • Referrals • Patients triaged	**Impact** • FFT score for cohort • RTT score for specialty Number of: • Discharges in secondary care • Operations • Patients managing their own care (PAM score) • Inappropriate referrals • Face-to-face appointments
Activity Number of: • Participating practices • Participating consultants • Referrals through triage service	**Outcome** • Patient satisfaction measures • Professional satisfaction measures Number of: • Avoided referrals • Face-to-face appointments • Referrals received in total • Referrals by practice	

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Opportunities for improvement: Rethinking referrals

1. MSK Clinical Review and Triage – Case study

The challenge

Secondary care providers of orthopaedic services in East Kent were failing to meet the 18-week referral to treatment target.

The intervention

The CCG introduced a locally-designed and managed GP triage approach for all new referrals to secondary care. The aim was to reduce waiting times and ensure patients get the best care. The purpose of the new service model 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

The triage service was delivered by a local GP consortium (Ashford Clinical Providers) whose GPs had specific experience and expertise in musculoskeletal disorders. 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.

Outcome

Since implementation of the triage service in Dec 2014, referral levels to secondary care from Ashford remain **40%** lower than during the pre-triage peak period and slightly lower than the 2013/14 baseline.

Further information and case studies

You can find further details about this work, as well as other case studies, in NHS England's MSK and Orthopaedics case studies directory. For more information, please email: england.electivecare@nhs.net

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2. Standardised referral template

What is a standardised referral template?

A standardised MSK referral template is a document available on primary care IT systems that guides referrers to provide appropriate referral information. The template **improves the quality of referrals** and **underpins effective triage**, thereby helping patients to be directed to the right care setting, first time. It complements a single point of access covering, for example, a T&O and MSK service.

Why implement a standardised referral template?

A standardised referral template can **reduce the number of inappropriate referrals** and **improve the quality of referral information received**, ensuring that referral criteria are met and sufficient details are transferred with the patient at the point of referral. This means that patients who need to be seen by a hospital consultant are seen as quickly as possible, ensuring the patient is directed to the right person, in the right place, first time. CCGs must have clear referral criteria for MSK services, including conditions covered and clinical indications for referral, which are communicated to all GPs. A standardised referral template can ensure that these criteria are explicit and understood.

Implementation - how to achieve success:

☐ **Establish a cross-system implementation team** that includes all stakeholders such as orthopaedic consultants, MSK service, GPs, practice managers and hospital-based managers, and both CCG and Acute trust leads.

☐ **Engage and communicate regularly with key stakeholders throughout the implementation process**. Use CCG communication networks such as newsletters and GP events to build awareness and uptake among GPs; sharing positive feedback can be powerful.

☐ **Agree outcome measures** to evaluate the impact of the template (e.g. feedback from referrers, number of referrals received). Ensure sufficient administrative support resources for evaluation.

☐ **Review the standardised referral template and work with lead clinicians** from primary, secondary and community care to tailor it to local services.

☐ **Ensure the form integrates with local Advice & Guidance services**. Consider how this will work and involve stakeholders from the start.

☐ **Seek IT advice and support as early as possible** to ensure the form can be uploaded to GP clinical systems and adjustments to improve usability can be made (such as automatic pop-up and pre-population of patient details).

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Opportunities for improvement: Rethinking referrals

2. Standardised referral template

How to achieve success (continued):

☐ **Seek feedback throughout the process from stakeholders** e.g. from local GP councils and patient user forums and act on their comments. Consider rapid pilots of the template in selected practices to test usability. Ensure necessary amendments are made to the template based on this feedback.

☐ **Communicate the final pathway and template to stakeholders** using a range of methods such as email, newsletter, practice meetings and host education sessions. Include a point of contact for referrers who may require support using the form.

Measuring impact:

The table below includes some of the metrics devised by the sites in Wave 1 of the Elective Care Development Collaborative as part of their logic modelling, along with additional suggestions. It is not an exhaustive list, but serves as a starting point.

Suggested metrics to measure success (this list is not exhaustive)		
Input • Number of hours to develop template • Associated costs	**Output** Number of: • GP written referrals made • Patients triaged using the standardised referral template	**Impact** • DNA rate • Wait time until first outpatient appointment • Wait time for follow up outpatient appointment Number of: • GP referrals rejected • Face-to-face appointments • Follow up appointments
Activity • Proportion of GPs using a standardised referral template • Size of specialty-specific patient cohort	**Outcome** Number of: • Patients discharged from secondary care • Unnecessary GP referrals	

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Opportunities for improvement: Rethinking referrals

2. Standardised referral template – Case study

The challenge

Patients in Fylde Coast were often referred to multiple specialties, including MSK and Pain Management, sometimes with insufficient referral information. This prevented effective triage and resulted in a number of inappropriate referrals. As a result, it could take several appointments at various specialties for a patient to find the right person to see.

The intervention

A cross-system team was established in Fylde Coast to devise and implement a standardised referral template to be used by primary care as a single point of access for referrals to the MSK triage service, covering MSK, T&O and Pain Management Services.

The template was developed collaboratively by primary and secondary care and piloted with 5 GP practices across Fylde Coast and Blackpool CCGs. Prior to piloting, the template was introduced to local Practice Managers' Bodies where it was discussed with all GPs (not just the pilot practices.) IT advice was sought from the beginning and the template was made available on the practice computer system (EMIS).

GPs completed the rest of the template and attached it to a referral on ERS. The template reflected GP comments, ensuring it was an easy-to-use tool that included automatic pop-up and pre-populated fields. Evaluation was carried out throughout the process.

Outcome

- More than **90%** of the 155 referrals to the MSK triage service used the template (**48%** of the templates were complete)

- The template supported the decision to redirect **23%** of referrals into a more appropriate specialty

Further information and case studies

Somerset also piloted a standardised referral template.

You can find further details about Somerset and Stockport's work, as well as other case studies, in NHS England's MSK and Orthopaedics case studies directory. For more information, please email: england.electivecare@nhs.net

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3. First Contact Practitioner (FCP) service

What is a First Contact Practitioner service?

A First Contact Practitioner is usually an Advanced Practice Physiotherapist who has the advanced skills necessary to assess, diagnose and manage musculoskeletal problems. A First Contact Practitioner service enables patients who would usually present to the GP in primary care with an MSK issue to either refer themselves directly into existing physiotherapy services or see a First Contact Practitioner who is based in general practice.

Why implement a First Contact Practitioner service?

Patients presenting with MSK make up to 30% of primary care consultations and 10% of all GP referrals. Enabling people to self-refer to first contact MSK practitioner services can **speed up access to treatment, reduce GP workload and associated costs, reduce prescription costs, increase self-management and reduce inappropriate referrals** to secondary care. Self-referral into physiotherapy can cut costs by £33 per patient.

Implementation - how to achieve success:

☐ **Establish a cross-system implementation team** that includes all stakeholders such as orthopaedic consultants, MSK service, GPs, practice managers and CCG leads.

☐ **Engage and communicate regularly with key stakeholders throughout the implementation process.** Use CCG communication networks such as newsletters and GP events to build awareness and uptake among practices; sharing positive feedback can be powerful.

☐ **Review current local MSK pathway, models of care, levels of referrals to orthopaedics/rheumatology and investigations.** Compare your gap analysis with national guidelines and good practice examples.

☐ **Work with stakeholders to agree changes to commissioning models and ways of working** that support change and address transitional issues as services are redesigned.

☐ **Look for opportunities to innovate.** Focus on relocation of existing Advanced Practitioners and shift of triage and post-op care to primary care.

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Opportunities for improvement: Rethinking referrals

3. First Contact Practitioner (FCP) service

How to achieve success (continued):

☐ **Establish the workforce model for implementation.** Identify knowledge and skills gap to introduction of First Contact Practitioner services. Work with local workforce action boards, training providers, employers, apprenticeship programmes and Community Education Providers Networks (CEPN) to upskill the workforce and increase numbers of advanced practitioners.

☐ **Ensure appropriate banding for the First Contact Practitioner role.** Most are currently 8a. Take account of advanced practice skills integral to the role: independent prescribing, injection therapy, analysis of diagnostics and investigations, leadership of service integration and innovation.

☐ **Develop robust clinical governance systems** with strong leadership and clear accountability. Establish close collaboration between clinicians in primary and secondary care to agree shared solutions and clinical governance arrangements.

☐ **Integrate the First Contact Practitioner services into local referral pathways.** Ensure First Contact Practitioners are present in primary care both as part of a GP team and a larger physio or multi-disciplinary team in secondary care/the community. Agree onwards referral routes (e.g. secondary care, frailty, social care).

☐ **Negotiate local agreements with radiology departments** for First Contact Practitioners to order investigations required.

☐ **Ensure a range of patient access options.** For example, through General Practice, community and independent providers.

☐ **Address training needs.** Work with your local CEPN and existing physiotherapy/MDT providers to support existing staff in First Contact Practitioner posts and facilitate networking to share continuing professional development and peer learning. Ensure First Contact Practitioners can provide specific training and development of GP reception staff and care navigators.

☐ **Design marketing materials.** Work with local communications teams to design compelling marketing materials for patients, promote the First Contact Practitioner services directly to people in the community, e.g. in GP practices, pharmacies and patient groups and keep GPs and specialist teams informed about First Contact Practitioner services.

☐ **Establish a feedback mechanism.** Proactively gather feedback from patients on the First Contact Practitioner service and how it might be improved. Establish processes to make any necessary changes.

Right person, right place, first time

Opportunities for improvement: Rethinking referrals

3. First Contact Practitioner (FCP) service

Measuring Impact

The table below includes suggested metrics. It is not an exhaustive list, but serves as a starting point.

Suggested metrics to measure success (this list is not exhaustive)			
Input	• Amount of time invested • Specification of stakeholders involved • Costs of training (£) • Patient cohort size	**Output**	• Number of patients accepting offer to see FCP • Number of patients seen by FCP who would otherwise have been seen by a GP • Costs of interventions (£) • Number of repeat appointments with GP
Activity	• Number of patients seen by FCP who would have seen the GP	**Impact**	• Waiting times across pathway • Patients who return to & stay in work • Conversion rates for orthopaedic surgery • Reduced MSK demand in secondary care

(Outcome column:)

Outcome
- £ prescribing related to MSK
- Patient satisfaction measures
- GP satisfaction measures

Number of:
- Patients requiring GP appointment
- Referrals for further treatment (needs to be identified)
- Referrals for orthopaedic/ rheumatology opinion
- Patients discharged to self-manage

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# 3. First Contact Practitioner (FCP) service – Case studies

The challenge

Traditional GP referrals to MSK services require patients to attend a GP appointment before being put on a waiting list to see a specialist. This can lead to delays in access to treatment, increased GP workload and inappropriate referrals to secondary care.

The interventions

In West Cheshire, a GP physiotherapy service was piloted across 36 practices and was then expanded to evening appointments. The capacity of the service stands at 11,000 patients per year, which is 25% of total GPs' MSK caseload. Quick access to advice provides rapid return to function and no need for further treatment. There is scope to increase the capacity of the service further. The service was developed with a successful clinical triage assessment and treatment service already in place. Outcomes were positive, with high satisfaction with the service from both GPs and patients.
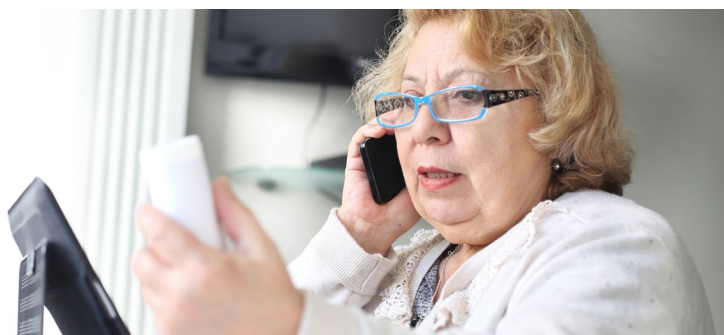
Outcome

- 60% of self-referred patients were discharged after the first appointment. 3% of self-referred patients needed to see the GP for reasons such as medication reviews or non-MSK conditions.

- 99% of patients rated the service as good or excellent and were happy to use it again. 91% rated the service 8+ for benefit to their practice. 45% rated the service 10/10.

- ➜There were 20% fewer referrals to MSK physio therapy services (after 5 years of an annual 12% increase) resulting in a reduction in waiting times.

- Annual savings: 84% patients would have seen the GP saving £540k, 4% less MSK imaging saving £11,495, 5.9% fewer X-rays saving £28k, 2% fewer orthopaedic referrals saving £70k.

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Opportunities for improvement: Rethinking referrals

3. First Contact Practitioner (FCP) service – Case studies

The interventions (continued)

In Nottingham there was a 12% referral rate to orthopaedics by GPs. Therefore, a 12 month pilot of a First Contact Practitioner service was undertaken, with 2 GP practices involved. 555 patients were seen by 2 GP physios, providing 2 half days each week.

In Darlington, a First Contact Practitioner service was implemented in December 2015 and results were recorded until the end of September 2016, with practice-based GP physios seeing 1147 patients. Four GP surgeries were involved.

The outcome

54% of patients were discharged after the first appointment (71% in total after the first or second appointment). 27% were referred to physiotherapy in secondary care, with 2% to the GP, 3% for diagnostics and 1% to orthopaedics. This reduction in referral to orthopaedics resulted in savings of £3,085 per patient.

70% of patients reported continuous improvement at 6 months. 80% of 350 patients across the 2 sites were satisfied with: the service, the information provided and their confidence in practitioners.

The outcome

Only 2% of patients needed to see the GP. 74% of patients discharged to self-manage. Consultant to consultant referrals reduced by 18%: saving £26k in 7 months. High patient satisfaction was recorded:

- 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.

Further information and case studies

You can find further details about Nottingham and West Cheshire's work, as well as other case studies, in NHS England's MSK and Orthopaedics case studies directory. For more information, please email: england.electivecare@nhs.net

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Opportunities for improvement: Rethinking referrals

3. First Contact Practitioner (FCP) service – Case studies

Measuring Impact

The table below includes suggested metrics. It is not an exhaustive list, but serves as a starting point.

Key priority data collection areas	

• MSK demand in secondary care
 	
• Referrals for orthopaedic/rheumatology opinion
 	
• Conversion rates for orthopaedic surgery
 	
• Referrals for injections, radiology, physio treatment in secondary/community, pain management services
 	
• Costs: MSK medicine prescribing costs, cost of investigations
 	
• GP capacity:
   • Repeat MSK appointments at GP surgery
   • Patients seen by FCP who would have seen the GP
   • GP feedback
	• Patients' capacity to self-care
	   • Patients discharged to self-manage
	   • Patients referred/signposted to physical activity or prevention services
	
	• Patient experience
	   • Patient feedback
	   • Waiting times across pathway
	   • MSK patients who return to work and stay in work
	
	• Shared Decision Making
	   • Patient related outcomes
	   • Process measures
	   • Healthcare practitioner feedback

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Opportunities for improvement: Shared decision making and self-management support

4. MSK self-management education

What is MSK self-management education?

Self-management education supports patients to understand and manage their own condition effectively. It enables patients to understand the variety of options available to them and facilitates informed, shared decision making. Self-management education encourages and empowers patients to take responsibility for their own health and wellbeing through behavioural change and improve their quality of life. It follows NICE guidance on self-management interventions (CG177, 1.3.2) and can be provided in various ways for example: through local workshops or as an online resource.

Why implement MSK self-management education?

Effective self-management education has the potential to **increase levels of Patient Activation**. Highly activated patients are more likely to adopt healthy behaviour, to have **better clinical outcomes** and **lower rates of hospitalisation,** and to report **higher levels of satisfaction** with services. It should also **increase the quality and amount of information available to patients and practitioners**, along with their understanding of their condition and their ability to self-manage. This can **reduce the workload** for health professionals and **delay the need for surgical intervention**.

Implementation - how to achieve success:

☐ **Establish a cross-system team to design the education workshops.** Include GPs, extended scope practitioners (ESP), pharmacists, surgeons, pre-op nurses, patient reps and allied health and wellbeing professionals.

☐ **Engage and communicate regularly with key stakeholders throughout the implementation process.** Use CCG communication networks such as newsletters and GP events to build awareness and uptake among practices; sharing positive feedback can be powerful.

☐ **Identify target group and engage with patients and clinicians to understand their needs** (test sites targeted people with hip and knee osteoarthritis). Ensure the education is tailored to their needs.

☐ **Review national guidelines** and good practice examples. Use your gap analysis to understand whether you need to set up new education options or signpost to existing offers.

☐ **Decide on the format for the offer.** Options include face-to-face and online education. Agree the desired length of session (typically 90 minutes).

Opportunities for improvement: Shared decision making and self-management support

4. MSK self-management education

How to achieve success (continued):

☐ **Ensure the education sessions are accessible.** Offer the education at a range of times (day time and evenings) and make resources available online (e.g. recordings of advice provided in face-to-face sessions).

☐ **Identify admin support.** Establish processes to manage referrals and self-referrals, including sending invites, booking patients, on-the-day registration etc.

☐ **Find and book a venue for the education session.**

☐ If this is an online session, organise a webinar and circulate details and instructions.

☐ If this is a face-to-face session, book a convenient community venue and inform participants about parking, accessibility, etc.

☐ **Co-design the agenda and content.** Include talks and Q&As on self-management techniques, treatment options available and risks and benefits. Link to other self-management support such as patient passports if available. Invite local health and wellbeing support services to host stands/give a talk at the event.

☐ **Agree who will deliver the education sessions.** Consider who is best-placed to deliver the education locally (e.g. GP or ESP) and build dedicated time into their schedules to do this. Ensure at least one talk is delivered by a relevant surgeon to support the self-management message by secondary care. Consider including two expert patients with opposite experiences of surgical treatment.

☐ **Design marketing materials.** Work with local communication teams to keep GPs and specialist teams informed about the education sessions.

☐ **Integrate the education into local referral pathways and promote the education directly to people in the community.** For example in GP practices, pharmacies, patient and community groups.

☐ **Establish a feedback mechanism.** Proactively gather feedback from patients on the education offer and how it might be improved and establish processes to make any necessary changes.

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Opportunities for improvement: Shared decision making and self-management support

4. MSK self-management education

Measuring Impact

The table below includes some of the metrics devised by the sites in Wave 1 of the Elective Care Development Collaborative as part of their logic modelling, along with additional suggestions. It is not an exhaustive list, but serves as a starting point.

Suggested metrics to measure success (this list is not exhaustive)					
Input	• Amount of time to prepare the self-management education intervention • £ associated costs (time/resources)	**Output**	• Number of sessions held • Percentage of patients reporting increase in knowledge scores • Percentage of patients reporting increase in confidence	**Outcome**	Number of: • Patients having self-cared before presenting to GP • Patients taking proactive measures to manage condition referrals • Face-to-face appointments • DNAs • Patients participating in peer support Percentage increase in: • Confidence scores • Knowledge scores
Activity	Number of: • Short courses developed • Invites sent • Attendees at workshops • Questionnaires returned • Patients in cohort	**Impact**	• Number of patients discharged from secondary care • PROMS and PREMS scores • FFT score for cohort		

Right person, right place, first time

4. MSK self-management education – Case study

The challenge

Stockport's orthopaedics service reported that they were seeing a high number of patients with knee osteoarthritis who could benefit from self-management support.

The intervention

Following NICE guidance (CG177, 1.3), 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 team ran three 90 minute workshops aimed at patients over the age of 50, who have been diagnosed with osteoarthritis (OA) and who have not yet been referred to secondary care. Between thirty and forty people attended each workshop.

The workshops were delivered by a multi-disciplinary team including a GP, pharmacist, pre-op nurse, physios and allied health and social care organisations. Individuals were referred by local orthopaedic services and GP practices. The workshops were also advertised in the community to attract self-referral, including in libraries, pharmacies, golf and leisure clubs and GP practices. The workshops included information on: What OA is, conservative management (physio and exercise), pain management, and surgical options (risks and benefits). They also featured stands run by local community organisations, highlighting support available locally.

The outcome

50% of attendees were self-referred. Of the 83 feedback questionnaires, the event increased the number of patients who felt very confident managing their OA, by more than 650% (increase from 8 to 61 patients.) Around 90% of attendees responded that they were likely or extremely likely to recommend the event.

Further information and case studies

You can find further details about Stockport's work, as well as other case studies, in NHS England's MSK and Orthopaedics case studies directory. For more information, please email: england.electivecare@nhs.net

Right person, right place, first time

Opportunities for improvement: Shared decision making and self-management support

5. Patient Passport

What is a patient passport?

A patient passport is a document that supports people with MSK conditions to take an active role in their care, self-manage effectively and access support when they need it. It adheres to NICE guidance on patient information (CG177, 1.3.1). The passport encourages users to make shared decisions about their care and provides information on self-management techniques and support available locally.

Why implement patient passports?

Patient passports help to **educate and empower patients to self-manage their condition**. The information they contain can help to ensure that **patients have the correct expectations of the outcomes following surgery**. If taken to appointments, patient passports can provide a written record of the steps patients are already taking to self-manage their condition and have the potential to **support shared decision making** about their care.

Implementation - how to achieve success:

- ☐ **Establish a cross-system team to lead implementation.** Include GPs, MSK practitioners and allied health professionals, along with local communications teams.

- ☐ **Engage and communicate regularly with key stakeholders throughout the implementation process.** Use CCG communication networks, such as newsletters and GP events, to build awareness and uptake among practices; sharing positive feedback can be powerful.

- ☐ **Identify a target group and engage with patients and clinicians to understand their needs** (test sites targeted people with hip and knee osteoarthritis). Ensure the passport is tailored to their needs.

- ☐ **Review existing** patient passports. Consider how these might be adapted to meet local needs.

- ☐ **Agree outcome measures** to evaluate the impact of the passports (e.g. patient satisfaction, professional satisfaction). Ensure sufficient administrative support resources for evaluation.

- ☐ **Ascertain a baseline** for all outcome and impact measures.

- ☐ **Assign a project lead.** This person will co-ordinate developing draft content for the passport and confirm how other team members and stakeholders will contribute (e.g. via email or meetings).

- ☐ **Find out as soon as possible about the local publications approval process.** This needs to include timescales, along with any style or logos guidance that must be adhered to. Build these considerations in to the development of the passport.

- ☐ **Agree format and content for the passport.** Seek IT advice and support as early as possible if a digital format is to be used.

- ☐ **Identify which services to signpost to,** such as healthy lifestyle support and smoking cessation.

Right person, right place, first time

Opportunities for improvement: Shared decision making and self-management support

5. Patient Passport

How to achieve success (continued):

☐ **Pilot the passport** for a locally agreed time in order to allow for review and redesign based on users' feedback.

☐ **Disseminate the passport.** Work with local communications teams to keep GPs and specialist teams informed about the passport and how it can be best used. Use locally agreed clinical channels (test sites used the GPs and the MSK service) and give them out at patient education workshops.

☐ **Develop training for professionals.** Consider whether local clinical and non-clinical professionals require training in how to use the passport.

☐ **Establish feedback mechanisms.** Proactively gather feedback from patients and professionals to see how the passport might be improved and establish processes to make any necessary changes.

Measuring Impact

The table below includes some of the metrics devised by the sites in Wave 1 of the Elective Care Development Collaborative as part of their logic modelling, along with additional suggestions. It is not an exhaustive list, but serves as a starting point.

Suggested metrics to measure success (this list is not exhaustive)					
Input	• Number of hours of time invested to develop/create and educate • Associated costs	**Output**	Number of: • Passports distributed • Patients actively using passports • Professionals reporting patients presenting with passports	**Outcome**	• Number of patients noticing a change in their behaviour due to the passport • Number of patients who have found passport useful • % increase of knowledge due to passports
Activity	• Passports development			**Impact**	• Number of first time appointment discharges in primary care • % change in utilisation of ancilliary wellness services

Right person, right place, first time

Opportunities for improvement: Shared decision making and self-management support

5. Patient Passport – Case study

The challenge

Under the current system, patients often expect a surgical solution to achieve full pain relief and full joint mobility, even when this is not clinically possible. This leads to patients' medicalisation and increases demand for elective care. In cases where the surgery does not yield expected results, patients attend multiple follow up appointments, with unrealistic hopes of regaining joint function and mobility.

The intervention

A patient passport (locally called Self Help Guide) was introduced in Fylde Coast. It aimed to empower patients with GP-diagnosed OA who have not yet been referred to secondary care; giving them the understanding and confidence to manage their conditions in the community prior to referral, thereby increasing their quality of life without medicalisation. The passport aims to give patients a realistic expectation of their outcome following surgery, reducing the amount of unnecessary follow up appointments. It adheres to NICE guidance and includes self-check exercises.

The draft of the passport was led by an MSK consultant and service support lead. Local Authorities provided a list of public health services available across the CCGs' footprints. Some of the self-care and self-check content was inspired by online Arthritis Research UK materials.

Opportunities for improvement: Shared decision making and self-management support

5. Patient Passport – Case study

The intervention (continued)

The draft was circulated widely for comments and subsequently finalised in a smaller group of MSK consultants, a service support lead and both CCGs' representatives. It was published as an A5-sized booklet. Overall, the guide uses minimum clinical terms, consistently encouraging patients to help their joint pains themselves. This highlights the message of de-medicalisation and self-care.

The patient passport was primarily handed out at patient education sessions, but it is also envisaged that it will be given out by GPs and/or physios. A follow up workshop questionnaire was sent to attendees about 3 weeks after the event. The questionnaire sought feedback on the passport, trying to understand whether attendees had used it subsequently.

Fifty seven patient passports were handed out at 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. The majority of users (71%) found the information useful and nearly a third (29%) had used the self checks.

The outcome

71% of patients found the information useful and nearly a third had used the self-checks.

Further information and case studies

Stockport and Somerset's 100 day challenge teams also piloted MSK patient passports. You can find further details, as well as other case studies, in NHS England's MSK and Orthopaedics case studies directory. For more information, please email: england.electivecare@nhs.net

6. Telephone follow up

What is telephone follow up?

Telephone follow up allows selected patients (e.g. post-intervention or post-diagnostic) to access healthcare virtually as opposed to face-to-face.
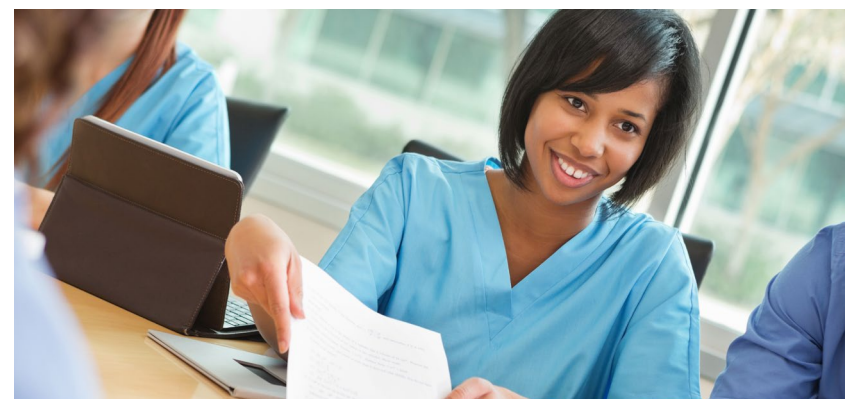
Why implement telephone follow up?

Telephone follow up improves access to care, as this is often more convenient for patients (e.g. saving time spent off work). It may also reduce appointment length and DNAs. Appointments can often be nurse or enhanced scope practitioner-led and thus save consultant time and clinic management resources.

Following their 100 day challenge, Stockport reported that 69 telephone follow up appointments were offered. 11 patients did not attend, but of the 58 telephone follow ups attended, 34% of patients were discharged following their telephone appointment, with 47% listed or referred for another procedure/investigation, thereby avoiding an unnecessary appointment.

Implementation - how to achieve success:

☐ **Establish a cross-system implementation team** that includes all stakeholders such as orthopaedic consultants, MSK service, GP, practice managers, CCG and Acute Trust leads.

☐ **Engage and communicate regularly with key stakeholders throughout the implementation process**. Use CCG communication networks such as newsletters and GP events. Engage with clinicians early on and allow time for discussion and constructive challenge; develop a pitch regarding the principles behind your approach.

☐ **Ensure appropriate facilities for staff conducting follow ups are available**. A telephone with a secure line, a computer and access to a dedicated quiet non-clinical room which allows privacy are essential.

6. Telephone follow up

How to achieve success (continued):

☐ **Establish demand and ensure there is workforce capacity to undertake telephone follow ups.** A multi-disciplinary team is required, including: Service manager to lead/co-ordinate the telephone clinics, practitioners (e.g. specialist nurses) or consultants to deliver the clinics, administrative staff to send out appointment letters.

☐ **Identify clinical criteria for patient-initiated follow up and for telephone follow up.** Co-develop and test your plans with orthopaedic specialists – they will help to secure the 'buy in' of other clinicians. Work with clinical directors and specialist teams to agree these criteria.

☐ **Agree outcome measures** to evaluate the impact of telephone follow ups (e.g. feedback from patients, number of face-to-face appointments avoided). Ensure sufficient administrative support for evaluation.

☐ **Identify patient cohorts and review existing clinic lists to select patients appropriate for phone follow up.** It may be useful to focus on several specific groups (e.g. hand, shoulder, hip and knee patients).

☐ **Identify patients who are already booked in for face-to-face appointments and reschedule them for a telephone review.** This can be time-consuming, but is a way to fill initial clinics.

☐ **Agree processes and protocols for inviting patients to telephone follow up.** Ask consultants to book patients for telephone follow ups straight after intervention or diagnostics, limiting 'doubling up' with face-to-face.

☐ **Set patients' expectations at the first contact.** Share clear details of the process and explain that follow-up is usually via virtual clinic, with face-to-face as an exception.

☐ **After the telephone consultation, confirm the results/management plan by letter.**

☐ **Capture patients feedback using digital surveys.**

☐ **Complete outcome forms (RTT) for each telephone follow up.**

Right person, right place, first time

Opportunities for improvement: Transforming Outpatients

6. Telephone follow up

Measuring Impact

The table below includes some of the metrics devised by the sites in Wave 1 of the Elective Care Development Collaborative as part of their logic modelling, along with additional suggestions. It is not an exhaustive list, but serves as a starting point.

Metrics to measure success		
Input • Amount of time taken to set up service • £ spent on face-to-face clinics • £ spent on telephony/web setup	**Input** • Number of contacts • Number of patient follow up calls • Number of contacts converted to face-to-face • Number of clinics run • Number of participating staff	**Impact** • Friends and family scores • Professional satisfaction measures • Patient satisfaction measures • Individual complication rates • % change in clinic time/space • Number of face-to-face appointment • Patient activation measure scores
Activity • Number of telephone follow up sessions • Number of patients offered option for virtual follow up • Number of DNAs • Number of participating practices/GPs	**Outcome** • Number of telephone clinics • Number of avoided secondary care referrals (consultant hours) • Number of face-to-face attendances in secondary care • DNA rates	

Right person, right place, first time

6. Telephone follow up – Case study

The challenge

Stockport's orthopaedics service was facing high clinic waiting times and staff were keen to utilise their clinic time more effectively.

The intervention

The team introduced telephone follow up appointments for hip, knee, shoulder and hand clinic patients to limit the time spent on routine post-intervention or post-diagnostics follow ups and eliminate the need for patients to come to hospital. It was piloted with all hip, knee, shoulder and follow ups, aiming to create a virtual fracture clinic in the future.

Existing clinic lists were used to select the specialties that the service would focus on. ESPs also identified suitable patients booked into face-to-face clinic appointments and rescheduled them for a telephone review. Initially the process was time consuming. However, in future, clinics should naturally fill up with direct requests from orthopaedic specialists.

Specialist nurses and ESPs run weekly telephone clinics. The telephone follow up processes are similar to face-to-face follow ups and are as follows:

- 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

Of 58 telephone follow ups 97% 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.

Further information and case studies

You can find further details, as well as other case studies, in NHS England's MSK and Orthopaedics case studies directory. For more information, please email: england.electivecare@nhs.net

Right person, right place, first time

Further resources

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 fewer from referral to hospital treatment.

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
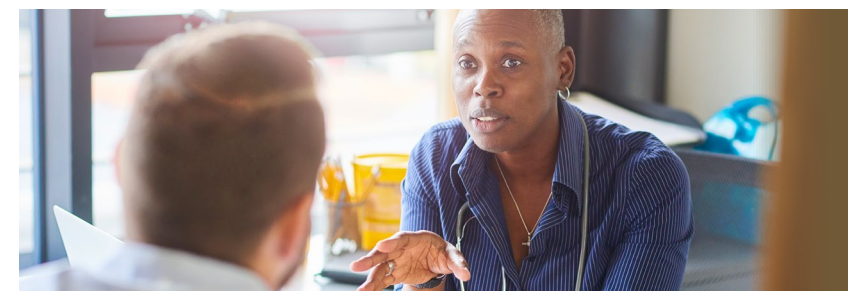
Right person, right place, first time

Further resources

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.

➜ NHS England's "Long Term Conditions Simulated Model Quick Start Guide" available at https://nhsengland.sharepoint.com/TeamCentre/TCO/NHSIQ/SIKnowledgeHub/SIcontent/Curated Content/simulation_model_quick_start_guide.pdf.

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.

Case studies and further evidence

• NHS England's Elective Care Case Studies pack provides a directory of case studies and contact details for those involved.

• NHS England's Demand Management Good Practice Guide support commissioners and providers to effectively manage demand for services, and includes innovative examples from across the country.

• Multiple resources on integration of MSK pathways are available on NHS Confed's website.

• SAIL guidance on routine letters between primary and secondary care.

Right person, right place, first time