Meeting:	**Social Care, Health and Housing Overview and Scrutiny Committee**
Date:	**12 April 2012**
Subject:	**Musculoskeletal (MSK) system redesign**
Report of:	**Tim O'Donovan, Service Redesign Manager – QIPP Planned Care Team**

Summary: The proposed change outlines a new model of Musculoskeletal (MSK) care in Bedfordshire that will, when commissioned, deliver:

a new model of care designed by the MSK clinicians, centred around patients, that focuses on the delivery of an integrated MSK system across BCCG localities and communities across Bedfordshire, with the overall aim of making sure patients receive the right care, at the right time, first time.

Advising Officer:	Paul Groom (Head of Commissioning Central Bedfordshire Council)
Contact Officer:	Tim O'Donovan (Service Redesign Manager, Bedfordshire Clinical Commissioning Group)

Public/Exempt:	Public
Wards Affected:	All
Function of:	NHS

CORPORATE IMPLICATIONS

Council Priorities:

1. The delivery of an effective MSK service will support the delivery of effective health services for residents and will impact on the Council's priortieis of supporting and caring for an ageing population and promoting healthier lifestyles.

Financial:

2. The financial impact is that there is scope for community services to be delivered for a more cost effective return in comparison to costs associated to hospital based care. There are anticipated savings in delivering care within the community.

Legal:

3. No legal implications to the Central Bedfordshire Council are anticipated

Risk Management:

4. The project progress, risks, issues will monitored by the QIPP Planned Care Board, who will ensure delivery and accountability for the project. The MSK project brief has been approved by the planned care board in October 2011 for project initiation. The Bedfordshire Clinical Network will provide clinical assurance to the system redesign and project implementation

Staffing (including Trades Unions):

5. Reassurance will be sought from providers on the areas below either through their response at PQQ/ITT or at panel. Workforce in the

- Right number
- Right skills
- Right place
- Right quality including TUPE

Equalities/Human Rights:

6. An initial equality impact assessment has been done and, no negative impact or specific issues have been highlighted at this stage

Community Safety:

7. Not applicable.

Sustainability:

8. More than half of the carbon footprint of the NHS in England is associated with the products and services it procures. Carbon emissions associated with the extraction, processing, assembly, packaging, transport, storage and handling of products and materials that are consumed directly and indirectly by service providers account for nearly 59% (11 million tonnes CO_2e) of the total carbon footprint.

   NHS Bedfordshire's ambition is to play a leading and innovative role at a regional and local level, ensuring a shift to a low carbon organization achieved through high standards of sustainable development, based on the principles of good corporate citizenship that will have positive impacts on health, expenditure, efficiency and equity.

   NHS Bedfordshire's Sustainability Policy (March 2011)

   - To minimise the environmental impact of travel in everyday business and commissioned services
   - To work in partnership to promote and achieve sustainable development throughout Bedfordshire

NHS Bedfordshire's Procurement Policy (June 2010) - Section 8.5.3

NHS Bedfordshire wishes to work with organisations that share a commitment to preserving the world's natural resources, and as far as reasonably practicable and consistent with procurement law and guidance, NHS Bedfordshire's procurement choices will favour products showing clear environmental advantages

Public Health

9. Public health implications as detailed in the report.

Procurement:

10. The procurement route chosen will be competitive tender to identify the best and appropriate provider

RECOMMENDATION:

The Committee is asked to support the proposal of an integrated MSK system across Bedfordshire, with an aim to deliver with better outcomes and improved quality of care for patients whilst realising improved value for money by incentivising a shift of resources from the acute setting to communities across Central Bedfordshire.

Background

11. The management of musculoskeletal conditions is currently primarily undertaken by rheumatologists and orthopaedic surgeons within an acute setting but do not have integration with other related MSK specialities within the community and primary care.

Problem with the current model of care

12. • Outdated, hospital-oriented system of care. This system was set up long before advances in physiotherapy, exercise and drug interventions resulted in opportunities for community-based services to achieve better outcomes and enable more efficient use of resources.

13. • Unwarranted clinical variation in activity. Differences in the treatment and care received for comparable conditions, with differences in access of that treatment/care.

14 • Lack of integration:

- Primary, community & secondary care
- Physical and mental health
- Health and social

15. • Variable service quality and customer experience

16. • Insufficient personalisation, support for self-care or shared decision making

17. • Unnecessary referrals into secondary care

18. • Duplication in services

19. • Multiple entry & exit points into system

20. • Multiple stand-alone contracts across the MSK system

21. The effect of this traditional model of care, delivers an over reliant hospital based model that results in a lack of coordination, integration of services, where patients find themselves being ping ponged around the system, experiencing unnecessary delays.

22. The release of national publications such as the Musculoskeletal Services Framework (2006) and Making the Shift (2006) make a strong case for the shift of resources from the acute setting into the community, delivering integrated multidisciplinary assessment and treatment, better value and improved patient outcomes.

Patient Journey now and in the future

23. Patients are currently referred by their GP to a number of different musculoskeletal services which tend to work in isolation from each other. The majority of MSK patients are referred to specialist consultants within secondary care, even though the majority of those patients (70%) do not require surgical intervention. Sometimes this means patients are not seen by the right service or could be receiving care from different professionals over the same period of time without a clear understanding of what treatment is offering the most benefit. If treatment offers little benefit, then patients are often required to go back to their GP for further referral. This can create unnecessary delays for patients in receiving the right care

24. We would like to start the proposed new musculoskeletal integrated service across Bedfordshire from April 2013. If we go ahead with our plans, patients will notice four important differences.

25. Main benefits to patients will be

25.1 Easier access to a community assessment and treatment service

Patients will have access to a MSK community team that will bring together the skills of physiotherapy Extended Scope Practitioners, specialist GPs, pain specialists and podiatrists alongside rheumatology and orthopaedic consultants. This will provide a comprehensive service that can assess and treat most patients in the community and so reduce the need to be referred to hospital. GPs would refer patients to the new service.

25.2 Telephone access

Telephone assessment and advice is an integral part of the service, helping patients to manage their condition around the demands of your work and home life. The philosophy is to provide early advice and management to help patients improve and prevent long term problems.

25.3. Central assessment of referral

Patient referrals will be sent into the new musculoskeletal service will be evaluated by an experienced MSK clinician to ensure patients access the right care at the right time, first time.

25.4. Rapid Access

Improved timely access to diagnosis and treatment within the community. Patients, where clinically appropriate, will still access hospital care

Integration between Health And Social Care (BCCG, Bedford Borough Council and Central Bedfordshire Council)

26. The proposed clinical model is built around integration of MSK specialities. It has also been recognised as feedback received from engagement primarily from patients and GPs, that patients in the proposed model receive timely access to commissioned social care services e.g. gym referral, exercise programmes, gentle swim initiatives.

27. Discussions have started with both Bedford Borough Council and Central Bedfordshire Council. The ultimate outcome of these discussions are that that relevant social care and public health commissioned services will accept direct referral at any appropriate part within the MSK patient pathway, and will not need to be referred back to their GP. This will help support ensuring patients are able to access support in timely manner and not receive unnecessary delays through fragmentation.

28. A project team has been developed comprising of an SRO, BCM and PM structure that is in line with NHS Bedfordshire Project best practice. The project has also a clinical lead, who chairs the Bedfordshire MSK Clinical Network meetings.

- Project Manager – Tim O'Donovan
- MSK Clinical Lead – Dr Andrew Edwards
- Business Change Manager – Alison Lathwell
- Senior Responsible Officer – Diane Gray

Supporting informed choice

29. By providing recommendations for referral, triage should not bypass the MSK patient in decision making. patients will be involved in shared decision making about choice of provider, choice of treatment, choice of healthcare professional and choice of location of care, e.g.: "No decision about me without me".

30. Patient choice will not be negatively affected. Patients will still continue to be offered choice by their GP of a secondary care provider for clinically appropriate surgical intervention. Where patients are receiving community intervention from the proposed MSK community service, patients will have improved access to multi-disciplinary teams and specialist consultant opinion.

31. The service will promote the use of telephone assessment and follow ups where appropriate or where the patient prefers. If a patient requires referral from the community MSK service to secondary care, patient choice of secondary care provider will come into effect.

32. Patient expectations can significantly affect perceptions of outcome, so patients need to understand what can and cannot be expected from their treatment or intervention. Time is well spent in listening to the concerns of patients and helping them to understand treatment options, so that treatment decisions match clinical need, and expected outcomes are achieved.

33. To assist patients to make choices, they will need access to:

    - Decision aids – such as pamphlets, DVDs and websites such as GPref designed to help people understand their options, consider the personal importance of possible benefits and harms, and participate in decision making

    - Information prescriptions – links or signposts to guide people to sources of information about their health and care

    - Voluntary sector advice – patient groups and charities which can provide a range of information to assist patients in how to manage their condition

    - Access to personal care planning tools – such as the Personal Health Plan which allows people to have greater ownership over their care and treatment.

Broader determinants of health benefit

34. As part of the implementation of an integrated service delivering MSK related interventions, there will be close links with social care which will ensure links into exercise referral schemes, gym access and swimming initiatives. Links have been made with public health pathways such as smoking cessation, tobacco control and weight loss to ensure further integration of services, and reducing the risk of patients experiencing unnecessary delays and inconvenience in access.

35. The expectation is that people with an MSK condition will be able to access rapid, integrated services that will help support and improve patients overall wellbeing. E.g. supporting people to remain in employment

36. An outcomes-driven approach to commissioning will be adopted which aims to get away from an activity based centrally-driven process, and deliver outcomes that matter most to patients. The NHS Outcomes Framework sets national outcome goals, across 5 domains. The MSK outcomes anticipated will be aligned with the 5 domains of the new NHS Outcomes Framework

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

37. For example:

- **Domain 3, helping people recover episodes of ill health or following injury**, by showing a reduction in the amount of patients readmitted within 28 days of admission of a planned care procedure
- **Domain 2, enhancing quality of life for people with long-term conditions,** by reducing average length of stay time spent in hospital by people with, long term MSK conditions
- **Domain 4, Ensuring that people have a positive experience of care,** Waiting time for MSK patient between first attendance at GP practice and first referral for specialist care e.g. Rheumatologist, orthopaedic surgeon.

38. Using Patient reported outcome measures such as the Oxford Hip & Knee Score or EQ-5D % of patients reporting an improvement in pain, mobility after treatment.