Full Business Case

Integrating Musculoskeletal Services

02 MARCH 2017
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1.0 Executive Summary
This business case presents the current state assessment and the case for integrating MSK Services. It then identifies options for future service delivery.

Current state
The overall CCG expenditure falls within the ‘Higher Spend, Worse Outcomes’ relative to other CCGs highlighting an opportunity to improve outcomes, furthermore the CCG spends £118 per weighted head of population, £20 cost per head over and above the England average of £98 for MSK conditions. If services continue to be delivered, as currently configured, the burden of care and financial pressure on the service will increase significantly and outcomes will not improve, becoming unsustainable. There are currently long wait times typically with referral to assessment in excess of six weeks and assessment to treat a further eight to ten weeks, although wait times can be longer for individual cases, with inefficient hand-offs. The waiting list for primary care physiotherapy, within Oxford Health Foundation Trust, is currently in excess of 2500 patients. (Elaine Arnott. Elaine.Arnott@oxfordhealth.nhs.uk. Evidence-based practice in the MSK redesign model. 2nd April 2015.)

This case for change sets out to determine how far current services are operating together as a cohesive whole to provide a seamless service for MSK patients making recommendation for change where the interface between services and/or providers creates barriers for them.

Options
Two options are presented within this paper:
1) To continue with the current configuration of service with contractual monitoring and developments made by providers, in line with effective clinical governance.
2) Implement a new integrated service that is based upon eight key areas of change

The key areas of change are:
   a. Self-management (please see appendix E for flow diagram)
   b. Self-referral (see section 4.2.1)
   c. Person centred care approach (care planning, shared decision making and patient centred outcomes) (see section 4.2.2)
   d. Networking with third sector (see section 4.2.2)
   e. Integrated Information Management system with viewing access for appropriate clinicians and patient (see section 4.2.3)
   f. Primary and secondary care interface meeting (see section 4.2.4)
   g. ‘One stop shop’ Integrating triage and assessment with primary care treatment
   h. Oxfordshire spinal pathways to be aligned with Pathfinder national spinal pathways

The option to continue with the current state will not significantly improve patient experience or generate savings and is unsustainable in the long-term.

The proposed integrated model is aligned with NHS England guidelines (NHS England, Jan 2015, Guidance on delivering personalised care and support planning: The journey to person-centred care) as well as guidance offered by Arthritis Research UK and the Arthritis and Musculoskeletal Alliance (ARMA) as well as other CCGs commissioning MSK services that are nationally recognised as flagship services.

The current waiting lists will need to managed and wait times reduced to two weeks prior to implementing a new service.
Financial
The proposed model will generate savings due to the current inefficiencies in the system, low conversion rates for spinal surgery i.e. approximately 20% (data source: Oxfordshire CCG HUB review 2014) and opportunities to include person centred care.

Best case savings with diversion of activity from secondary care to primary care:
£1 639 000 (£1 439 000 after MATT investment)
Worst case savings with diversion of activity from secondary care to primary care:
£984 000 (£784 000 after MATT investment)

The one off cost of managing the backlog on Primary Care therapy waiting lists is estimated at £482k on a worst case scenario.

Additional costs for Information Management will be incurred with estimates in the region of:
Set-up £100k one-off
Annual license and maintenance £100/annum

Recommendations
1. It is recommended that option B to implement the integrated care model is approved
2. It is considered with a high degree of certainty that the proposed model could be delivered by existing providers via contractual variation and it is recommended that existing providers are approached for expressions of interest as the preferred commissioning solution.
3. It is recommended that the Information Management solution outlined in the draft IM&T specification is progressed and expedited as part of the CCG wide IM&T strategy.
4. Opportunities exist to improve quality and facilitate shift of activity and cost into self-management by commissioning third sector services. It is recommended that these are explored further with Third Sector organisations with a view to commissioning.
Proposed Musculoskeletal Integrated Service Model

PUBLIC

Patient self-referral
Patient referrals
Referral Access & Signposting
- Clinical papertriage
- Patient Choice & Booking

MSK Assessment Triage & Treat (MATT):
- Same day diagnostics
- Person-Centred Care
- Primary Care Physiotherapy & Podiatry
- Non-resolving MSK problems (orthopaedic medicine)
- Medicines advice/management

Self Management
Website and clinician advice

Voluntary Organisations
- Oxfordshire County Council Prevention
- Peer support
- Advice & guidance
- Alternative therapies

Other NHS services e.g.
- Community Physio
- Ancillary Health Care
- Pain Relief Unit
- Other GP services

MRI & CT Scans
Library (response time <5days)

Discharge with advice on self-management

Interface meeting (junior doctors, SPs and ESPs)
Non-operative interventions
Secondary Care Management (Surgery and Paediatrics)
Specialist therapy and rehabilitation
2 week wait

Secondary care opinion
Red flags

Primary Care
Secondary Care
2.0 Scope

2.1 Aims and Objectives

Aim
The project aimed to determine how far current services were operating together as a cohesive whole providing a seamless service for MSK patients and make recommendation for change where the interface between services and/or providers creates barriers for them.

Objectives
1) Implement a standardised model of care for MSK in Oxfordshire, eliminating inefficiencies and inconsistencies.
2) Ensure care is provided by appropriate clinicians in the right place, first time
3) Improve quality of service delivery
4) Improve cost effectiveness of service delivery
5) Improve collection of business intelligence

Commissioning options could include the implementation of appropriate contracting levers, focussing on service transformation or even the re-procurement of services.

Scope of service
The MSK service for people registered with an Oxfordshire CCG General Practice over 12 months of age are included within the scope of this review:

- Referral, triage and assessment processes
- Patient choice and appointment booking
- Orthopaedics
- Rheumatology
- Podiatry
- Primary Care Physiotherapy
- Specialist Physiotherapy
- Women’s Physiotherapy
- Orthotics
- Diagnostics
- Rehabilitative pain management
- Special requirements for patients with a learning disability
- Special requirements for patients with a mental health condition
- Special requirements for patients with congenital physical disability
- Access for patients entering the health system via the falls prevention service
- Access for patients entering the health system via Minor Injuries and Trauma

Exclusions
- Chronic pain management
Musculo-Skeletal Scoping Diagram

Patients include:
- Age > 12 months
- Patients with a learning disability
- Patients with congenital physical disability
- Patients with a mental health condition

2nd care Consultants
GPs
Community providers
Third sector E.g. Oxfordshire Sports Partnership

Initial referrals
Patient choice
Choose & Book
Post surgical
Rheumatology

Referrals
Integrating MSK services
Triage clinicians
Triage clinicians
GPs

Assessment
Primary diagnosis
Paper triage
Face to face triage
Face to face consultation
Diagnostics

Treatment
Surgery
Pain management (exc. chronic)
Specialist Physio
Podiatry
Rheumatology
Rehab Physio
Orthopaedics
Community Physio

Referrals
Minors & Book

Follow-ups

Therapists
Patients

Minor Injuries Falls service
Referral & assessment links with these services?

GPs
Triage clinicians
Third sector E.g. Oxfordshire Sports Partnership

Chronic Pain
Follow-up links to this service?

2nd care Consultants
Patients

Patients with a learning disability
Patients with a congenital physical disability
Patients with a mental health condition

Therapists
Patients

Third sector E.g. Oxfordshire Sports Partnership

E.g. Oxfordshire Sports Partnership

Patients with congenital physical disability
Patients with a mental health condition

E.g. Oxfordshire Sports Partnership
3.0 Reasons for Investing In This Project

Due to continued high costs of provision, reported delays in assessment and treatment and high level of GP dissatisfaction with the referral and triage processes, Oxfordshire CCG has commissioned a review of its commissioned MSK services with a view to:

- Improving quality of service and therefore patient experience
- Optimising efficiency of care pathways
- Ensuring value for money

The overall CCG programmes spend for MSK problems amounts to £61,124,177 based on 2011/12 figures provided by NHS England (see Fig 2 below): This includes prescribing, urgent and emergency care and non-elective spend, which are not included within the scope of this project but are shown here as part of overall cost for MSK used by NHS England for national benchmarking.

**Fig 2: Programme Budgeting Showing MSK Spend**

![Bar chart showing MSK spend as £61,124,177](http://www.england.nhs.uk/resources/resources-for-ccgs/prog-budgeting/)

The largest proportion of MSK spend was in secondary care (£47,460,000) equating to 77.6% of the total MSK programme spend. In October 2012 Oxfordshire CCG commissioned KPMG consultancy to review spend in planned care services: KPMG reported that, for MSK services, Oxfordshire achieved mixed outcomes with a heavy focus upon acute settings of care as the primary delivery point of services. Other causes for additional spend could be issues such as:

- Clinical variation in practice
- Access to and therefore potentially overuse of more specialised services as well as;
- Lack of integration with community, rehab and physiotherapy services

The NHS England SPOT Spend and Outcome Factsheet (2012/13) reports that within this MSK programme, the overall CCG expenditure falls within the ‘Higher Spend, Worse Outcomes’ relative to other CCGs highlighting an opportunity to improve outcomes (see fig 3).
The CCG spends £118 per weighted head of population, £20 cost per head over and above the England average of £98 for MSK conditions. The CCG is performing around the national median for orthopaedic Patient Reported Outcomes for Hips however, there is scope and opportunity for the CCG to redesign services to ensure value for money and improve outcomes across the whole model of care.

Current conversion rate for elective spinal surgery is 20% (data source; hub review May 2014). There is significant scope for seeing and treating patients in primary care to avoid secondary care first and follow ups where surgical procedure is not required.

3.1 Strategic Context

3.1.1 National strategic context

In 2006 the Department of Health published ‘The MSK Framework - a Joint responsibility: Doing it differently’. The vision of the framework is that people with MSK conditions can access high-quality, effective and timely advice, assessment, diagnosis and treatment to enable them to fulfil their optimum health potential and remain independent. The Department of Health proposes this is achieved through systematically planned services, based on the patient journey, and with integrated multidisciplinary working across the health economy.

MSK disease is one of the most prevalent long-term conditions, affecting around ten million people across the UK; with 137 people per 1,000 cite a long-term condition1, and accounts for the fourth largest NHS programme budget spend3 of £5 billion in England4. MSK problems are significantly expected to rise between now and 2030 with the ageing population, increasing rates of obesity and low rates of physical activity 2. For example, the number of people with arthritis in the UK is expected to rise from 8.5 million to 17 million.
A radical transformational change is required to improve the end-to-end system of MSK patient care, also to integrate the MSK services with effective interface and integration with community, rehabilitation and physiotherapy services, providing a more effective and efficient service for patients based on outcomes. Put financial efficiencies into the service provided through promoting innovation and seek to provide better value for money than the current model.

The Department of Health’s MSK Service Framework (2006) promotes a fully integrated care pathway and also makes a strong case for the shift of MSK resources from the acute setting into the community, and delivering integrated multidisciplinary assessment and treatment that ultimately produces better value and improved patient outcomes.

**Evidence that integrating MSK services can work**

An integrated outcome approach has gained a very high profile nationally and is quite widely utilised in the USA and parts of Europe. In the UK, the approach is rapidly gathering momentum with many CCGs already closely examining the benefits integrated care can bring to the NHS. Oldham is an example of already established integrated services for MSK.

The Pennine MSK Partnership provides a service commissioned by Oldham CCG specifically to co-ordinate the delivery of MSK care funded via a programme budget and prime contractor approach. The Pennine partnership example has demonstrated a more effective care pathway showing benefits from the removal of unwarranted variation and duplication. By having a single and clinically led pathway service, with clear accountability and budget for the whole pathway, quality and productivity, Pennine MSK Partnership is able to use clinical judgment and skills to improve both the patient experience and value for money element. This model of commissioning and delivery has developed over a ten year period.

### 3.1.2 Local Context

Oxfordshire’s population is growing due to increased inward migration, particularly in the urban hubs of Oxford and Banbury and the proportion of older people is likely to continue increasing with implications for service demand (JSNA 2014). The overall population of Oxfordshire is forecast to grow by only 0.3% from 2011 to 2017 for under 65. The proportion of the population aged over 65 will grow from 15.8% to 18.2% by 2017.

The number of people with MSK conditions is rising by about 1% per year.

**Local development of Oxfordshire CCG’s MSK services**

Oxfordshire CCG’s MSK services are currently provided under different contracts with various providers that have been commissioned at different times and have not been designed to work together within an integrated model of care. Several attempts have been made over the last six years to improve provision of these services in order to build confidence in an effective, timely and value for money MSK service, but the focus of review and change has tended to be on discreet areas of service rather than the whole system. The Hub was introduced in 2009 to manage referrals and appointment booking as well as shift inappropriate activity away from secondary care and into community based services, or back to primary care. The expiry of the MSK Hub contract in 2015 creates an opportunity to explore a commissioning strategy for an integrated MSK Service.

The case for change and the approach being taken will be aligned with Oxfordshire CCG’s five year strategy and plan 2014/15 - 2018/19 and the NHS Outcomes framework.
Objective one of this project meets Oxfordshire CCG’s most significant improvement intervention, focussed on integrating services around the patient and wherever possible providing accessible services closer to the patient’s home.

Alignment with Oxfordshire CCG’s corporate objectives 2018/19:
- Objective 2: Streamlined planned care pathways, with more opportunities to access planned care closer to home and fewer outpatient referrals.
- Objective 4: Deliver fully integrated care, close to home, for the frail elderly and people with complex multi-morbidities.

Alignment with Oxfordshire CCG’s 2018/19 vision for Health and Social Care:
- Facilitating a significant step towards providing health and social care that is rated amongst the best in the country for all its citizens in terms of quality, outcomes and local satisfaction with services.
- ‘Delivering parity of esteem in mental and physical health care’
- ‘Engaging the patients/public’ in understanding the current state and future state redesign
- ‘Delivering quality and innovation’ via focus on quality of service as the prime driver in innovative
- ‘Reducing the amount of time spent avoidably in hospital through the provision of better integrated care in the community.’

The case for change is also aligned to the NHS Outcomes framework domain 3 and 4:
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care

Please see Appendix B for detail on the current state analysis

3.1.3 Constraints
- The MDT chronic pain service in the Churchill hospital is excluded from the scope of the project due to MSK representing only a fraction of the total patient population in the service, hence this was deemed out of scope.
- Constraint due to physical location of local services as they need to be collocated with certain facilities. However all potential premises that are suitable to provide these services have been identified.

3.1.4 Dependencies
- Dependent on Information Management and Technology Strategy Board, introduction on information management technology is now dependent on the board to approve
- Dependent on cooperation of General Practitioners (contractual mandate).
- For maximum effectiveness, there is a dependence on the primary and secondary care interface.
- Dependent on the training provided as part of the personalisation agenda
- Training for clinicians and staff members on person-centred care in particular care planning.

3.1.5 Critical Success Factors
The following critical success factors are proposed taken from this analysis and where other CCGs that have implemented integrated MSK services:
- Efficient triage and referral to appropriate clinician first time
• Seamless services with joined up working between providers
• Excellent Communication between clinicians/ providers
• Coordinated whole pathway management
• Patient Centred Service
• Access to services must be provided in locations and facilities that meet local patient need
• Providers must demonstrate sufficient capacity and operational ability to deliver services required to service specification
• Supporting patient independence

3.2 Current Position and Case for Change

Based on available data if services continue to be delivered, as currently configured, the burden of care and financial pressure on the service will increase significantly and outcomes will not improve. Please see Appendix B for detail on the current state analysis.

Overall CCG expenditure currently falls within the NHS England ‘Higher Spend, Worse Outcomes’ quartile, relative to other CCGs. At £20 cost per head over and above the England average of £98 for MSK conditions the service is not currently offering good value for money and is not sustainable.

By focussing on the complete pathway, the intention was to explore the interface between different services and providers of those services across the patient pathway, identifying potential inefficiencies and inconsistencies in order to inform and define a future state ‘integrated’ MSK service that is not inhibited by current contractual arrangements.

H S J Picavet (2003) studying the health related quality of life of persons with one or more self-reported MSK diseases concluded that patients with multiple MSK diseases had the poorest health related quality of life. It is essential that MSK services are aimed at improving quality of life.

The primary drivers for this project are to improve quality of service, with an expectation that efficiency savings will be realised as inefficiencies and issues are addressed. This project will be concerned with delivering outcomes relative to the real costs it takes to deliver those outcomes.

3.2.1 Case for Integration with pathway management

• Oxfordshire is currently £20 cost per head over and above the England average of £98 for MSK conditions.
• Overall CCG expenditure falls within ‘Higher Spend, Worse Outcomes’ relative to other CCGs in NHS England SPOT comparison for 2012/13.
• Opportunity to integrate more community services into the MSK pathway shifting care closer to patients home and seeing a shift of spend more towards lower cost community services
• Sound evidence base for integrating MSK services nationally (e.g. Pennine for Oldham CCG) and internationally (especially USA)
• MSK Pathway is currently restricted by organisational and/or historical boundaries
• Breakdown in communications between clinicians (inter and intra)
• Confusion in a complicated, convoluted system
• Delays between different steps in the patient pathway
• Patients not always being seen in the right place first time
• Poor clinical information sharing between providers
• Too many steps in the patient pathway
• Lack of clarity around provider responsibilities (contractual)
• Lack of discharge process and continuity of care
• Single point of contact required for patients

3.2.2 Case for reviewing the patient choice and booking system
• Choice not always offered, or communicated effectively, or in a timely way
• Insufficient slots available
• Long delays in the patient pathway
• Growing GP antagonism with Choose and Book

3.2.3 Case for developing timely, comprehensive, patient information
• Information not being provided to patient at time of referral (if at all),
• Patients don’t understand process/ pathway
• Patients not informed on self-care (pre-operative and between stages)

3.2.4 Case for developing joint decision–making tools
• Patients do not generally feel well-informed on options.
• Lack of joint decision-making
• Patients’ not sufficiently informed on the outcomes, risks and benefits of surgery
• Sound evidence base for successful implementation

3.2.5 Case for developing an information management system
• Patients confused by the system
• Patients find it difficult to know who to contact
• Patients anxious if waiting with no information about progress of referral
• Poor provider interface result in wasted clinician and patient time (e.g. re-assessment)
• Opportunity exists for utilising the in-house system currently being developed

4.0 Stakeholder engagement

4.1 Engagement summary
For further detail please see appendix A

To thoroughly consider the redesign of Oxfordshire MSK services a number of engagement activities were undertaken in two phases:
• Forming a Patient Advisory Group (PAG)
• Forming a Clinical Advisory Group (CAG)
• Holding all stakeholder co-design events
• Experience Based Co-Design (EBCD)
• Follow-up focus groups (clinicians and patients)
• Public survey
• One to one liaison with patients and clinicians

Patient Advisory Groups (PAG)
A PAG was established at the beginning of the project with 25 members throughout the
lifetime of the project. Members were drawn from Talking Health (OCCGs online consultation tool), locality patient forums and stakeholder networks.

Clinical Advisory Groups (CAG)
A CAG was established during phase one of the project, with GP representation of every locality and senior clinicians/ Clinical Directors from existing providers.

Phase one engagement – current state analysis
Four PAG meetings and eight CAG meetings were held to define and understand identified problems. Five cross-cutting themes and one pathway were identified as areas of focus:
1. Communications
2. Self-referral and direct referral
3. Shared decision-making tools
4. Prevention
5. Patient centred outcomes
6. Spinal pathway

Phase two engagement – future state analysis (co-design)
Patients and GPs assisted in a process of Experience Based Co-Design (EBCD). The group viewed a film of six local patients describing their MSK experience on film, allocated numeric values to patient experience along the patient journey and mapped it. Negative issues clustered around triage and assessment, whilst positive experiences clustered around first GP appointment and treatment, reflecting information from other sources (patient complaints, GP feedback on Datix, etc).

A public survey was posted on Talking Health (OCCG’s online consultation platform). OCCG’s Equality and Access Co-ordinators took the survey out in discussion group format to get a broad range of views from hard to reach community groups and networks. The survey aimed to test key findings identified during phase one engagement including access, communication and information:
- The public survey attracted 128 Talking Health members to complete.
- 89 people completed the public survey online
- 58 people participated in discussion groups based on the survey
- Attracted media coverage in four newspapers and mentioned by two radio stations.

Three all stakeholder workshops were held with an average of 64 people (patients, GPs, existing providers, third sector and Oxford University) engaging in a process of co-design to:
- Agree type, range and standard of services
- Scrutinise, debate and develop solutions into a service framework

At the first workshop, attendees working in specific allocated groups developed solutions to the six focus areas described above.

Solutions were developed by focus groups following this workshop.

At the second workshop attendees tested how potential solutions with identified risks and benefits to date would improve the patient experience.

Solutions were further developed by focus groups following this workshop with one key model proposed.

The third workshop scrutinised the practicability and efficacy of the draft model.
Several focus groups were held following the third event to refine the model and agree risks, assumptions.

A wrap-up seminar was held with patients, patient locality forum representatives and voluntary sector organisations to describe the finalised proposed model and describe the next steps for the project. A questions and answer session was held and the patients were thanked for their tremendous support.
5.0 The Business Options

5.1 Option A – Do nothing
Continue with the service as is currently being delivered across multiple providers, monitoring in accordance to contract.

5.2 Option B – Integrated Model
The integrated model involves eight key areas of change;
1. Self-management (please see appendix E for flow diagram)
2. Self-referral (see section 4.2.1)
3. Person centred care approach (care planning, shared decision making and patient centred outcomes) (see section 4.2.2)
4. Networking with third sector (see section 4.2.2)
5. Integrated Information Management system with viewing access for appropriate clinicians and patient (see section 4.2.3)
6. Primary and secondary care interface meeting (see section 4.2.4)
7. ‘One stop shop’ integrating triage and assessment with primary care treatment
8. Oxfordshire spinal pathways to be aligned with Pathfinder national spinal pathways

(Please see appendix E showing patient pathways for lower back pain and radicular back pain demonstrating how the model aligns with the national spinal pathways)
Please see appendix F for a draft service specification (to be worked up with stakeholders following approval of the business case if given).
5.2.1 Self-referral

**Definition of Self-Referral**

‘Patients are able to refer themselves to a therapist without having to see anyone else first, with or without being told to refer themselves by a health professional either electronically or by telephone.’ [Based upon the Allied Health Professional bodies definition of self-referral].

The national ‘Our health, Our care, Our say’ public listening exercise in 2005 indicated support for self-referral to allied health professions (AHP) services, and the resulting White Paper included the following commitment: ‘...in order to provide better access to a wider range of services, we will pilot and evaluate self-referral to physiotherapy. We will consider the potential benefits of offering self-referral for additional direct access for other therapy services’ (CSP 2009).
The Department of Health (2008) worked in partnership with six sites and the Chartered Society of Physiotherapy (CSP) to pilot self-referral to musculoskeletal physiotherapy. Demographic and clinical data relating to the population from the pilot sites was collected and analysed with some of the following findings:

- High levels of service-user satisfaction and confidence.
- A more responsive and attractive service to patients with acute conditions, affording them wider access.
- Empowering patients to self-care/ self-manage in order to meet their needs.
- Lower levels of work absence.
- No increase in demand for services.
- Accessed by males and females of all ages.
- No evidence that BME groups use self-referral less than white groups.
- Greater levels of attendance and completion of treatment.

The GP’s in Oxfordshire were invited to take part in a survey on whether they are in favour of self-referral. The results were; 93 (88%) in favour and 13 (12%) against patient self-referral to musculoskeletal services in Oxfordshire.

Further key points supporting the case for self-referral are as follows;

- Inequity in provision and access
- Self-referral fits with the NHS choice and personal control agenda
- Reduces GP time spent on MSK referrals.
- Reduces the number of GP appointments on MSK conditions.
- Self-referral is popular with patients and GPs
- Strong evidence base to support self-referral, pilots in Scotland and later in England found that self-referral has a range of benefits for patients, commissioners, GPs and employers.
- Self-referral has not demonstrated an increase in demand on services
- Drastically reduces the number of referrals being returned to the GP
- Increases efficiency
- High levels of service-user satisfaction and confidence reported
- No reported extra costs are incurred from self-referral

(Please see appendix D for further detail)

5.2.2 Person-centred care approach

Within the proposed MSK service, person centred care will include a public self-management advice website and an online care planning tool which will include within it; shared decision making aids, links to voluntary organisations and their services, quality patient outcomes with advice on how to self-manage their condition within a care plan.

Within OCCG’s stakeholder engagement for the musculoskeletal service redesign, five cross sectional areas were identified to be addressed within the new model. These were; prevention, communications, shared decision making, quality patient outcomes and self-referrals. The personalised care approach can incorporate elements of all five.

Evidence shows that personalised care and support planning can lead to the most appropriate use of limited healthcare resources. People who are engaged in their health and care are more likely to receive care and treatment that is appropriate to them; to take up appropriate prevention services (such as regular screening); and to adopt more healthy behaviour.
Further key points supporting the case for person centred care are as follows;

- Holistic approach for patients
- Promotes self-management which improves patient outcomes and increases value for money
- Involves patients in decisions about their care
- Tailored support to increase confidence and skills in self-management
- Greater value for money, as services provided meet individual needs, deliver improved health outcomes and reduce medicine wastage
- A positive impact on other local and national drivers, such as reducing acute admissions and improving the patient experience
- Complete fit with QIPP.
- Provides a long term, sustainable approach to reducing the burden of LTCs on local resources
- Patient has a better understanding of their condition
- The importance of person-centred care, support for self-management and personalised care planning has been highlighted in numerous policy documents over the past decade
- The NHS Constitution includes the right “to be involved in discussions and decisions about your health and care, including your end of life care, and to be given information to enable you to do this. Where appropriate this right includes your family and carers.” And also the commitment “to involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one”

(Please see appendix D for further detail)

5.2.3 Information management and technology (IM&T)
Communication between clinicians and providers and clinician to patient is critical for the success of this model, particularly around the person-centred approach. Please see appendix G for draft service specification for IM&T solution which is being developed as part of a CCG wide IM&T strategy in collaboration with the IM&T Board. Estimates for the development and provision of an integrated software system that supports self-management, care-planning and cross-boundary working are in the region of:

Developmental costs: £100k one-off
Annual license and maintenance: £120/ annum

(Please see Appendix I for estimates from Map My Health and Work Local)

5.2.4 Primary and secondary care interface meeting
The interface clinician only meeting (virtual or face to face if required) will ensure appropriate transition of patients from primary to secondary care to receive treatment following shared decision making with the patient. The outcome of the meeting will be communicated with the patient, next steps agreed with booking of appointment if required.

5.2.5 Third sector networking and involvement
Local Third Sector organisations that can offer valuable services to MSK patients are currently not utilised. Third sector organisation can offer extremely good value for money and are well placed to support patients outside of the Healthcare system, encouraging self-management and supporting lower cost provision of care. Examples are:

Here for Health can offer the following service for MSK patients:

- Provide a 'pop up' service within the different MATT sites
Undertake training to be able to advise MSK patients, including the care planning training for practitioners within the MSK service.

Act as the link between third sector and MSK patients. Sign post patients to relevant community services and the Here for Health centre.

Oxfordshire Sports Partnerships currently have the capacity to take on large volumes of patients until March 2016 as funding is secured until then and can offer the following services for MSK patients:

- ‘Go Active get healthy’ offers a tailored programme to people looking to get fit
- Motivational coaching is included in the service
- Specific activities for patients with MSK conditions
- Physiotherapists already refer to into the programmes offered and there are intentions to work together with physiotherapists to discuss activities for patients with MSK conditions for example Pilates and yoga etc. being good for strengthening
- Offer consistent messages around physical activity throughout the pathway
- Work with patients on their MSK care planning – include goal setting in the programme

Please see Appendix B for more details and estimated costs of services that would support the proposed integrated MSK service.

### 5.3 Appraisal of business options

As explained in the case for change the current status quo is not tenable. OCCG therefore needs to consider and evaluate the two options outlined in table 1 below:

**Table 1**

<table>
<thead>
<tr>
<th>Option</th>
<th>High Level Option Description</th>
<th>Is this option Feasible</th>
<th>If Feasible Will Delivering This Option Impact on Patient Quality of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Do Nothing</td>
<td></td>
<td>✗</td>
</tr>
<tr>
<td>B</td>
<td>Service Redesign to integrate MSK services</td>
<td>✓</td>
<td>Positive Impact</td>
</tr>
</tbody>
</table>

**KEY:**

✗ = Not Realistically Feasible

? = May be Feasible but Would Have a Number of Dependencies / Drawbacks

✓ = Feasible Option with Few Dependencies / Drawbacks

Each of the options listed in Table 1 above are further expanded and analysed. The impacted areas, timescales, costs and risks associated with implementing the preferred solution are then outlined in sections 5, 7 and 7 respectively.

### 5.4 Business Options Impact on Patient Quality of Care

Please see section 12.2 and 12.3
5.5 Evaluation of Business Options

Each of the two options presented in section 3 is evaluated using the following approach –

- an analysis of the benefits of implementing the option
- an analysis of the drawbacks of implementing the option

For the purpose of populating the table below the following abbreviations have been used:

5.5.1 Benefits

Table 2 below lists all the main benefits of the 2 options

<table>
<thead>
<tr>
<th>Potential Benefit</th>
<th>Option A</th>
<th>Option B</th>
<th>How will Benefit Be Measured</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 No investment required</td>
<td>✓</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>2 Continuity of current service</td>
<td>✓</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>3 Seamless, joined up coordinated care</td>
<td>-</td>
<td>✓</td>
<td>Reduced complaints relating to processes from patients and GPs, reduced phone calls</td>
</tr>
<tr>
<td>4 Single point of contact for patients for support across whole pathway</td>
<td>-</td>
<td>✓</td>
<td>Number of referrals going through RAS vs. total number</td>
</tr>
<tr>
<td>5 Consistent quality standards across all providers/services</td>
<td>-</td>
<td>✓</td>
<td>Agreed set of quality measures. Agreed by all providers</td>
</tr>
<tr>
<td>6 Redesigned seamless pathway with minimal steps in the patient journey</td>
<td>-</td>
<td>✓</td>
<td>Reduced number of patient appointments</td>
</tr>
<tr>
<td>7 Patients seen by the right person, first time</td>
<td>-</td>
<td>✓</td>
<td>Reduced number of patient appointments</td>
</tr>
<tr>
<td>8 Faster access to diagnostics</td>
<td>-</td>
<td>✓</td>
<td>Number of people receiving 1 stop shop approach v not</td>
</tr>
<tr>
<td>9 Improved efficiency of triage and assessment</td>
<td>-</td>
<td>✓</td>
<td>95% of referrals processed in 24 hours and 100% in 48 hours</td>
</tr>
<tr>
<td>10 Reduced wait times</td>
<td>-</td>
<td>✓</td>
<td>80% of patients to be seen within 10 working days.</td>
</tr>
<tr>
<td>11 Efficiency savings</td>
<td>-</td>
<td>✓</td>
<td>Reduction in cost of service</td>
</tr>
<tr>
<td>12 Pathway management</td>
<td>-</td>
<td>✓</td>
<td>Pathway coordinator to oversee patients move through system efficiently</td>
</tr>
<tr>
<td>13 Effective communication between providers and practitioners</td>
<td>-</td>
<td>✓</td>
<td>Patient information to be accessed by clinicians in the providers.</td>
</tr>
<tr>
<td>14 Developed primary/secondary care interface - up-skilling of Primary care in MSK</td>
<td>-</td>
<td>✓</td>
<td>Secondary care and primary care working together effectively in the interface meeting</td>
</tr>
</tbody>
</table>
### 15
**Built in option for self-referral leading to GP’s time being used for more complex patients**
- ✓
  - Number of referrals from GP’s reduced

### 16
**Improved patient satisfaction and experience of services**
✓
- Less complaints and improved patient satisfaction in surveys e.g. 80% of patients rating the service good or very good.

## 5.5.2 Disbenefits
Table 3 below list all the main drawbacks of the two options

**Table 3**

<table>
<thead>
<tr>
<th>Potential Drawback</th>
<th>Option A</th>
<th>Option B</th>
<th>How will Drawback Be Measured</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Change to existing practise may create tensions with existing provider (OUH) of the triage and assessment service (HUB)</td>
<td>-</td>
<td>✓</td>
<td>Patient waiting times and length of time it takes patients to move through system</td>
</tr>
<tr>
<td>2. Current disjointed and fragmented services continue</td>
<td>✓</td>
<td></td>
<td>Number of patients not receiving diagnostics in the MATT</td>
</tr>
<tr>
<td>4. Delays in accessing and turnaround of diagnostics</td>
<td>✓</td>
<td></td>
<td>Current state analysis</td>
</tr>
<tr>
<td>5. Limited access to physiotherapy and rehabilitation following discharge</td>
<td>✓</td>
<td></td>
<td>Outcomes in care plan being recorded.</td>
</tr>
<tr>
<td>6. Continued high use of resources with poor health outcomes</td>
<td>✓</td>
<td></td>
<td>Feedback from patients in satisfaction surveys. E.g. patients agree that they have choice</td>
</tr>
<tr>
<td>7. Resource commitment to audit of provider competences and compliance with service specification</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Little patient choice being offered across whole pathway</td>
<td>✓</td>
<td></td>
<td>Number of queries from providers.</td>
</tr>
<tr>
<td>9. Blurred provider contractual responsibilities</td>
<td>✓</td>
<td></td>
<td>Current state analysis</td>
</tr>
<tr>
<td>10. Ineffective use of resources continues</td>
<td>✓</td>
<td></td>
<td>Number of patient complaints</td>
</tr>
<tr>
<td>11. Inequitable quality of care continues</td>
<td>✓</td>
<td></td>
<td>Number of patients and GPs having to chase referrals.</td>
</tr>
<tr>
<td>12. Continued misuse of GPs/ practice time chasing referrals</td>
<td>✓</td>
<td></td>
<td>Number of patients not treated in the MATT.</td>
</tr>
<tr>
<td>13. Patients continue to be bounced between services</td>
<td>✓</td>
<td></td>
<td>Number of patient complaints</td>
</tr>
</tbody>
</table>
5.6 Proposed Option Summary

Based on the data presented in Sections two to four, Option B has been identified as the preferred solution. The preferred option is further analysed in sections five to seven below.

6.0 Impacted Business Areas

A review has been undertaken to identify likely impacts on key external stakeholders that are likely to occur, or will be required, during the actual delivery of Business Option B. These likely impacts are highlighted in section 12.4.

6.1 Process and Technology

6.1.1 Process

Assuming that existing providers will enter into agreement to deliver the proposed service via contractual variation table 4 provides a broad outline of the anticipated timeframe:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Proposed timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set up project Board including all stakeholders</td>
<td>May 2015</td>
</tr>
<tr>
<td>Establishing buy-in from existing providers</td>
<td>May 2015</td>
</tr>
<tr>
<td>Agree process – timescales and costs (if any) for managing the backlog on waiting lists</td>
<td>May 2015</td>
</tr>
<tr>
<td>Develop the draft service specification with existing providers and patients (see appendix)</td>
<td>May 2015</td>
</tr>
<tr>
<td>Complete Information Technology solution</td>
<td>In progress – needs to be expedited as the service cannot be implemented without this in place (at least minimum requirement)</td>
</tr>
<tr>
<td>Explore potential estates</td>
<td>May – June 2015</td>
</tr>
<tr>
<td>Explore workforce requirements and recruitment (include TUPE if required)</td>
<td>May - June 2015</td>
</tr>
<tr>
<td>Agree contractual variation</td>
<td>July 2015</td>
</tr>
<tr>
<td>Contractual agreement and signing</td>
<td>July 2015</td>
</tr>
<tr>
<td>Mobilisation period</td>
<td>August – October 2015</td>
</tr>
</tbody>
</table>

6.1.2 Technology

Please see section 4.2.3 Information management and technology (IM&T) and appendix G for further details.

7.0 Timescales

See Appendix C for project plan.
### 8.0 Major Risks

The major risks associated with delivering Business Option B are included in table 5 below:

**Table 5**

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Owner</th>
<th>Mitigating Action</th>
<th>Impact (1-5)</th>
<th>Likelihood (1-5)</th>
<th>Project Risk Rating</th>
<th>Post Mitigation Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pre-existing waiting lists creating additional demand (surcharge) on the service at implementation. Will not realise all efficiency savings</td>
<td>Planned care team</td>
<td>Address increasing pressures on current state system to reduce demand to steady state prior to implementation</td>
<td>5</td>
<td>4</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>2. Risk of OUH not collaborating with new pathway</td>
<td>Project/ Clinical Lead</td>
<td>Adopt most appropriate contracting approach and mechanism with OUH</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>3. Savings estimates over-inflated leading to unable to realise planned savings</td>
<td>Project Lead</td>
<td>Ensure assumptions are reasonable with expected or pessimistic values and evidenced where possible</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>4. Self-referral inducing increased volumes of activity (demand) with greatest peak at initial implementation. Increased costs, risk of delays and increased wait times</td>
<td>Project Lead</td>
<td>Avoid promotion of self-referral within initial implementation phase with phased in approach to introduce self-referral in first quarter</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>5. Risk of not meeting estimated shift of activity to self-care (self-management) in first quarter. Reduced savings and increased demand on service</td>
<td>Project Lead</td>
<td>Hard promotion of self-care from the outset, with appropriate staff training and communication with key healthcare providers and external agencies.</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>6. Interface meetings failing due to OUH non agreement, lack of planning and coordination or availability of appropriate clinicians</td>
<td>Joint QIPP steering group</td>
<td>Collaborative working with OUH prior to implementation and requirements clearly specified and worked through with new service provider(s).</td>
<td>4</td>
<td>1</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>7. New service provider(s) not delivering to specification, leading to reduced quality, reduced efficiency savings and reduced trust, collaborative working, with other stake holders</td>
<td>Contract Management</td>
<td>Comprehensive mandated specification developed by the CCG with GPs patients and provider(s). Commissioning solution ensures provider(s) keep to specification through a combination of incentives and penalties.</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>8. Risk of provider(s) not acquiring premises co-located or in close proximity to x-ray facilities. Service unable to operate as a same day service</td>
<td>Provider</td>
<td>Early discussions with providers providing clear specification clearly communicated and close collaborative working with the Community Health Partnership</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>9. Provider(s) fail to recruit to Extended Scope Practitioner and/or Dispensing Clinical Pharmacist roles</td>
<td>Provider</td>
<td>Use of existing ESP’s to provide early one stop shop assessment. Strengthen prescribing of staff involved in assessment phase. Use specialist nurses with prescribing skills.</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>10. Resistance to change threatens compliance with and success of new system</td>
<td>Provider</td>
<td>See 2 and 7.</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>-</td>
</tr>
</tbody>
</table>
9.0 Financial Analysis

9.1 Assumptions

Costing:
1. 50% of patients will migrate in first year from GPs to self-referral with no net increase in activity/costs
2. Only 2% GP referrals will go directly for urgent secondary care opinion
3. Secondary care clinicians will attend virtual primary/secondary care interface meetings
4. Secondary Care will refer to the MATT for appropriate Elective non-surgical and Post-operative Lower Back Pain follow-ups
5. The costs of managing the current backlog in waiting lists will be
6. The following estimates for clinician time are accurate:

See Appendix H for calculation of demand on the new service.

There is an assumption that all MSK referrals go through Direct Access physiotherapy within OUHT and OHFT and so the numbers of referrals from these services have been used to calculate the number of referrals that have been inputted to the activity based costing model.

<table>
<thead>
<tr>
<th>Patient type</th>
<th>Level of care</th>
<th>Proportion</th>
<th>Tolerance</th>
<th>Screening time</th>
<th>No. of appointments</th>
<th>Appointment time</th>
<th>Tolerance</th>
<th>Band</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice and information only</td>
<td></td>
<td>10</td>
<td>±5%</td>
<td>5</td>
<td>1 x MATT</td>
<td>45 mins</td>
<td>±5 mins</td>
<td>7</td>
</tr>
<tr>
<td>Fixed end point</td>
<td>Primary</td>
<td>50</td>
<td>±10%</td>
<td>10</td>
<td>3 x MATT</td>
<td>45 mins</td>
<td>±15 mins</td>
<td>1 x band 5 2 x ESP 6 x band 5/6</td>
</tr>
<tr>
<td></td>
<td>secondary</td>
<td>30</td>
<td>±10%</td>
<td>5</td>
<td>2 x MATT</td>
<td>45 mins</td>
<td>±15 mins</td>
<td>1 x band 6 1 x ESP</td>
</tr>
<tr>
<td>Complex</td>
<td>Primary</td>
<td>5</td>
<td>±2%</td>
<td>8</td>
<td>3 x MATT 6 x Physio</td>
<td>45 mins</td>
<td>±15 mins</td>
<td>1 x band 5 2 x ESP 6 x band 5/6</td>
</tr>
<tr>
<td></td>
<td>secondary</td>
<td>5</td>
<td>±2%</td>
<td>8</td>
<td>3 x MATT 6 x Physio</td>
<td>45 mins</td>
<td>±15 mins</td>
<td>1 x band 5 2 x ESP 6 x band 5/6</td>
</tr>
</tbody>
</table>

Proposed Savings:
1. 10% savings on costs of physiotherapy (currently GP Direct Access Physiotherapy) due to self-management
2. 10% reduction in cost of diagnostics
3. 5% reduction in cost of appointments in community services
4. 8% efficiency savings on costs of community services (HUB review found rate referred back with same problem NOC data 6% South East data 10%)
5. 5% substitution saving at 50% tariff
6. 5% reduction in elective surgical procedures.
7. X% (tba) savings on specialist physiotherapy moved from secondary to primary care
Other potential savings:
1. General Practitioner time reduced by an estimated 15% due to less referrals via the GP (assuming 50% self-referral and 30% GP time spent with MSK related conditions)
2. Specialist secondary care physiotherapy can be provided by Extended Scope Practitioners in Primary Care (MATT service). Not quantifiable due to no split on secondary care data
3. Transport to secondary care as a result of reducing number of appointments to secondary care.
4. Reduced activity for orthopaedic procedures other than spine (not quantifiable due to insufficient or inaccurate data)
5. Reduced costs in Rheumatology services through reduction in non-inflammatory activity by Consultant led secondary care to ESP led Primary Care services with consultant support/ interface. Not quantifiable due to insufficient data.

Proposed Savings

10% savings on primary care costs due to self care
10% savings on diagnostics
5% efficiency savings e.g. patients seen by right clinician first time
3-5% savings across the whole service, due to reduction in exacerbation and relapse
10% substitution saving due to reduction of spinal procedures
10% increase in costs due to a shift of secondary care (spinal procedures) activity into primary care
## Table 1 Current MSK services costs based on 2013/14 SUS and SLAM

<table>
<thead>
<tr>
<th>Trust</th>
<th>Services</th>
<th>Total activity (appointments)</th>
<th>Cost £</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oxford Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapy</td>
<td></td>
<td>13744</td>
<td>1 891 000</td>
</tr>
<tr>
<td>Podiatry (MSK )</td>
<td></td>
<td>4787</td>
<td>222 595</td>
</tr>
<tr>
<td>Orthotics</td>
<td></td>
<td>3411</td>
<td>129 990</td>
</tr>
<tr>
<td><strong>Total OH</strong></td>
<td></td>
<td></td>
<td><strong>2 243 585</strong></td>
</tr>
<tr>
<td><strong>Oxford University Hospitals Trust</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapy (NOC Consultant referrals)</td>
<td></td>
<td>4102</td>
<td>122 460</td>
</tr>
<tr>
<td>Physiotherapy (NOC GP referrals)</td>
<td></td>
<td>68</td>
<td>1 779</td>
</tr>
<tr>
<td>Horton</td>
<td></td>
<td>9579</td>
<td>304 933</td>
</tr>
<tr>
<td>Churchill</td>
<td></td>
<td>755</td>
<td>24041</td>
</tr>
<tr>
<td>Physiotherapy (EOHC)</td>
<td></td>
<td>10 444</td>
<td>350 489</td>
</tr>
<tr>
<td>Physiotherapy (JR consultant ref)</td>
<td></td>
<td>12 062</td>
<td>391 889</td>
</tr>
<tr>
<td>Physiotherapy (GP referral)</td>
<td></td>
<td>655</td>
<td>22 193</td>
</tr>
<tr>
<td>OUHT physiotherapy (site not identified GP ref)</td>
<td></td>
<td>133</td>
<td>4 859</td>
</tr>
<tr>
<td>OUHT physiotherapy (site not identified consultant ref)</td>
<td></td>
<td>284</td>
<td>10 024</td>
</tr>
<tr>
<td>Podiatry</td>
<td></td>
<td>8460</td>
<td>1 007 000</td>
</tr>
<tr>
<td>Orthopaedic Outpatients new</td>
<td></td>
<td>32 942</td>
<td>4 052 860</td>
</tr>
<tr>
<td>Orthopaedic Follow up</td>
<td></td>
<td>57996</td>
<td>4 316 435</td>
</tr>
<tr>
<td>Rheumatology New</td>
<td></td>
<td>324</td>
<td>77 294</td>
</tr>
<tr>
<td>Rheumatology Follow up</td>
<td></td>
<td>962</td>
<td>104 823</td>
</tr>
<tr>
<td>Rheumatology procedures (OP)</td>
<td></td>
<td>115</td>
<td>67 803</td>
</tr>
<tr>
<td>Surgery (IP and DC)</td>
<td></td>
<td>5825</td>
<td>21 762 000</td>
</tr>
<tr>
<td>Spinal surgery (non specialist)</td>
<td></td>
<td>313</td>
<td>1 428 000</td>
</tr>
<tr>
<td>MSK Hub referrals</td>
<td></td>
<td>19000</td>
<td>836 000</td>
</tr>
<tr>
<td>Hub face to face</td>
<td></td>
<td>6000</td>
<td></td>
</tr>
<tr>
<td>Orthotics (band A-I)</td>
<td></td>
<td>16017</td>
<td>1 145 000</td>
</tr>
<tr>
<td><strong>Total OUHT</strong></td>
<td></td>
<td></td>
<td><strong>36 962 079</strong></td>
</tr>
<tr>
<td><strong>Overall total</strong></td>
<td></td>
<td></td>
<td><strong>38 273 467</strong></td>
</tr>
</tbody>
</table>

It should be noted that due to poor information the physiotherapy activity and finance may not be accurate and the likelihood is that there is more activity than that available and therefore costs are higher. This impacts’ on the view of the potential savings available.
### Assumptions and Predicted Savings

<table>
<thead>
<tr>
<th>Assumption applied</th>
<th>Cost following assumption £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall; 50% patients move from GP referral to self-referral (CSP 2011)</td>
<td></td>
</tr>
<tr>
<td>• 10% reduction in overall activity due to self-management (in primary care)</td>
<td></td>
</tr>
<tr>
<td>• 5%-10% reduction in secondary care activity due to self-management and care planning</td>
<td></td>
</tr>
<tr>
<td>3-5% reduction in orthopaedic surgery due to improved care planning and reduced exacerbation</td>
<td>653 - 1088</td>
</tr>
<tr>
<td>3-5% reduction in spinal surgery due to improved care planning and reduced exacerbation</td>
<td>43 - 71</td>
</tr>
<tr>
<td>10-20% fewer new patients to orthopaedics</td>
<td>122 - 203</td>
</tr>
<tr>
<td>10-20% fewer follow ups in orthopaedics</td>
<td>130 - 216</td>
</tr>
<tr>
<td>3-5% Reduction in physiotherapy costs</td>
<td>370 - 62</td>
</tr>
<tr>
<td><strong>Total predicted savings</strong></td>
<td><strong>984 - 1639</strong></td>
</tr>
<tr>
<td>Additional MATT costs</td>
<td>Circa 200</td>
</tr>
<tr>
<td>(After current costs for physio and MATT taken into account)</td>
<td></td>
</tr>
<tr>
<td><strong>Overall predicted savings</strong></td>
<td><strong>784 – 1439</strong></td>
</tr>
</tbody>
</table>

It is expected that there will be additional costs relating to the MATT being provided across 6 localities but some of this cost (if not all) is offset by the efficiencies gained from reducing assessment and treatment times described in the table on page 29. There are additional savings from a further 10% reduction in diagnostics activity (10% has already been achieved from clearer guidelines being agreed). The main areas are likely to be in ultrasounds and MRI particularly of the spine.

### 9.2 Cost of managing existing waiting lists

There are currently long wait times typically with referral to assessment in excess of six weeks and assessment to treat a further eight to ten weeks, although wait times can be longer for individual cases, with inefficient hand-offs. The waiting list for primary care physiotherapy is currently in excess of 2000 patients.

Table 6 indicates the cost of reducing of the waiting times to zero but will in practice only need to be reduced to two weeks and is therefore reporting on a worst case scenario.

*Table 6: Data for OUHT Direct Access Physiotherapy is not available so estimates have been made on proportionate annual activity with OHFT and OUH annual costs and activity*
10.0 Achievability
- The successful engagement with all stake holders including main providers, patients, GPs and third sector leading to the co-design of a new model has generated enthusiasm amongst stake holders and provided a sense of ownership as well as determination amongst clinicians to realise the change required to be successful. GPs as commissioners have demonstrated their support of this proposed model at locality meetings and GPs as providers have also indicated their support of specific changes within the proposal e.g. a survey of opinion on self-referral yielded an 88% vote in favour of the motion.
- It is considered that the proposed model could be implemented and delivered by existing key providers via contractual variation.
- The model is supported by Oxfordshire CCGs personalisation agenda with regards to train the trainer in care planning.
- The model is supported by the OCCG’s IM&T strategy to develop an integrated information management system across provider boundaries with patient access.
- The proposed integrated model for Oxfordshire is based on the same principles as other CCGs with leading MSK services (considered to be flag ship services e.g. Sheffield CCG and Coastal West Sussex.) These CCGs provide a sound evidence base to achieve best clinical practise while generating savings.
- The arthritis and musculoskeletal alliance (ARMA) acknowledge the proposed integrated model for Oxfordshire (option B) is aligned with vision ARMA have for the future of MSK services which has been endorsed by NHS England.
- This option will generate savings.
- There is an existing workforce within the two key providers with the required skill mix and skill level.
- The new service would facilitate the personal professional development of allied health professionals, encouraging recruitment and retention.
- Estates are in close proximity to existing x-ray facilities (and in some cases MRI and CT) to allow the MATT (one stop shop) to be formed.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Target</th>
<th>Baseline position</th>
<th>Evidence Base</th>
<th>Frequency of assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threshold target for meeting person centred</td>
<td>75%</td>
<td>No baseline</td>
<td>MATT data</td>
<td>monthly</td>
</tr>
</tbody>
</table>

11.0 Performance and Activity
The new model is centred around the patient, hence performance needs to be measured against person-centred outcomes agreed with individuals.

Additional performance indicators to those already set for triage, assessment primary and secondary care treatment are proposed in table 7 below:

Table 7

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Target</th>
<th>Baseline position</th>
<th>Evidence Base</th>
<th>Frequency of assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number on waiting list</th>
<th>Unit cost of episode of care</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapy (OHFT)</td>
<td>2584 (actual)</td>
<td>£138</td>
</tr>
<tr>
<td>Physiotherapy (OUH)</td>
<td>1300 (estimate)</td>
<td>£90 (estimate based on annual costs and activity SUS 2013/14)</td>
</tr>
<tr>
<td>Podiatry (OHFT)</td>
<td>1198 (actual)</td>
<td>£46.50</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
12.0 Commissioning Solutions:
The needs of the health care service users are currently being met in terms of quality of provision and quality of treatment, but convoluted pathways, a lack of clarity over provider boundaries and lack of integration of information management systems are not helping Providers in their delivery of efficient and timely service across the patient journey from referral to treatment. The proposed changes to service required by option B would facilitate Providers in meeting their contractual requirements and strengthen their ability to deliver a higher quality, better value for money service. It is considered that the existing Providers are best placed to deliver the proposed service against the specification and may do so by contractual variation. Alternative commissioning solutions should only be considered if agreement cannot be reached with existing Providers.

Please see Appendix J for more detail

13.0 Right Care Opportunities:
The right care commissioning packs have highlighted a number of opportunities for savings across MSK. Some of which will be addressed as part of the implementation of this service model, the details of which can be seen below:

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Issue</th>
<th>How it will be resolved as part of the project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osteoporosis</td>
<td>Rate of DEXA scan activity</td>
<td>High level of DEXA scanning</td>
<td>Better triaging and treatment through the MATT</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>Rate of hip replacements</td>
<td>Low hip arthritis prevalence but high hip/knee replacement procedures</td>
<td>Better triaging and treatment through MATT</td>
</tr>
<tr>
<td>Trauma and Injuries</td>
<td>Injuries due to falls in over 65s</td>
<td>High level of falls in this age group compared to other CCGs</td>
<td>Part of the new service payment is outcome based, one of which is to link with and refer onto the falls service</td>
</tr>
</tbody>
</table>
14.0 Recommendations
1. It is recommended that option B to implement the integrated care model is approved
2. It is considered with a high degree of certainty that the proposed model could be delivered by existing providers via contractual variation and it is recommended that existing providers are approached for expressions of interest as the preferred commissioning solution.
3. It is recommended that the Information Management solution outlined in the draft IM&T specification is progressed and expedited as part of the CCG wide IM&T strategy.
4. Opportunities exist to improve quality and facilitate shift of activity and cost into self-management by commissioning third sector services. It is recommended that these are explored further with Third Sector organisations with a view to commissioning.

15.0 Impact Assessments

15.1 Privacy Impact Assessment and IG Checklist for Projects

Privacy Impact Assessment – Project 54 Integrating MSK Service Redesign
Author: Colin Sullivan  Date: 25th March 2015

The following information will be incorporated into the full business case template for the project. Reference has been made to the CSU Privacy Statement to ensure that the service redesign is conducted to comply with the data protection act in mind. The project is being managed to ensure that features pertinent to privacy are considered at the appropriate time. This separates into two distinct periods of time:
1. Pre-approval: The period through to submission and approval of the full business case where Information Governance is pertinent to redesign
2. Implementation: The implementation period (contract variation or other procurement options) where new service contracts must ensure alignment with the Data Protection Act 1998.

The questions listed in the table below suggest which aspects of Information Governance are likely to be relevant in the pre-approval phase and those which may be relevant within the implementation phase:

<table>
<thead>
<tr>
<th>PIA Screening Questions</th>
<th>Pre-Approval Phase</th>
<th>Implementation Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will the project involve the collection of new information about individuals?</td>
<td>X (x)</td>
<td>X (x)</td>
</tr>
<tr>
<td>Will the project compel individuals to provide information about themselves?</td>
<td>X (x)</td>
<td>X (x)</td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Does the project involve you using a new technology which might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Will the project result in you making decisions or taking action against individuals in ways which can have a significant impact on them?</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For example, health records, criminal records or other information that people would consider to be particularly private.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Will the project require you to contact individuals in ways which they may find intrusive?</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

The project lead is cognisant of the requirement to address the items marked under YES within the pre-business case phase column. It is the opinion of the project lead, following discussions and agreement with the Information Governance Officer that all factors have been taken into account.

The implementation phase will require the project lead to ensure that those areas marked under YES in the implementation phase column are adequately addressed and managed to deliver full compliance as the project moves towards delivery of the new service.

**It is critical that the project lead ensures that the Data Protection Act 1998 is adhered to by provider(s) and this should be a feature of any contractual/procurement process.**
15.2 Quality Impact Assessment

## Quality Impact Assessment (QIA) form - Stage 1

The following assessment screening tool will require judgment against four domains of risk in relation to Quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations. Where adverse impacts score greater than (>2) is identified in any area then this will result in the need to undertake a more detailed Quality Impact Assessment. This process will be supported by the Quality and Innovation Directorate.

### Section 1 - to be completed by Project Lead / Clinical Lead

<table>
<thead>
<tr>
<th>Scheme Name</th>
<th>Integrating Oxfordshire Musculoskeletal Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheme Overview</td>
<td>Efficient service delivery across all MSK services in Oxfordshire from referral through to follow-up, improving patient experience within cost effective services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project Lead</th>
<th>Clinical Lead</th>
<th>Programme</th>
<th>Planned Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colin Sullivan</td>
<td>Dr Rob Russ</td>
<td>_</td>
<td>_</td>
</tr>
</tbody>
</table>

#### Quality/indicator(s)

- To be detailed in the service specification but will include KPIs on access, patient experience and clinical effectiveness.

#### KPI Assurance - Sources & Reporting to Monitor Quality Indicator(s)

- Monthly contract meetings.

For each of the domains of quality below, please enter a brief description of any areas that could possibly impact on quality (i.e. waiting times under patient experience). Then list whether the impact would be negative or positive. If negative, please enter a consequence and likelihood and a score will be calculated for you. You may enter upto three topics under each domain. DO NOT SCORE POSITIVE IMPACTS.

#### Patient Experience

**Does this project impact on patient choice, waiting times or any other patient experience measure?**

- Pre existing waiting lists creating additional demand (surcharge) on the service at implementation leading to failure of service to deliver to specification. Will not deliver quality of service with reduced wait times. N 4 4 16
- The referral access and signposting service has the potential to cause delays in the patient journey although the service is being designed to mitigate this risk. N 3 3 9
- Potentially that patients choice is not offered as per NHS constitution however comprehensive training for RAS team staff should mitigate this risk. N 3 3 9

#### Patient Safety

**Does this project impact on the safety of patients (environment, treatment, safeguarding, etc.)?**

- There is a potential for the new IT systems are not fit for purpose and may require further staff training in order to ensure clinical records are updated and appointments are not lost in the system. A clinical safety audit will be completed prior to launch to minimise these risks. N 5 3 15

#### Clinical Effectiveness

**Does this project impact on best practice guidance, clinical leadership/engagement, etc.?**

- There is a risk that there may be a variation in the quality of service between the different MATTs. Robust clinical governance will be specified in the contract to minimise this risk. N 3 3 9

#### Innovation

**Does this project use an approach that uses technology to reduce inefficiencies?**

- Care planning tools and a public advice website to be introduced. P 0
- Links with voluntary organisations to be incorporated into pathway - community resources to be utilised. P 0

### Overall Risk Score

<table>
<thead>
<tr>
<th>Scheme Number:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Risk Score</td>
<td>12</td>
</tr>
</tbody>
</table>

### Section 2 - to be completed by Quality Director

<table>
<thead>
<tr>
<th>Signed - Clinical Lead</th>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signed - Director of Quality</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Signed - Clinical Director of Quality</td>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>

Comments - Director of Quality
Quality Impact Assessment (QIA) form - Stage 2

The following assessment screening tool should be completed if there are any negative impacts on quality that had a risk score of greater than 8 on the stage 1 Quality Impact Assessment form. This form requires the project or clinical lead to answer a few questions on how quality could be impacted. Then, the user is asked to describe in detail how quality is negatively impacted before describing all actions with timescales as to how good quality will be preserved.

Scheme Name: Integrating Oxfordshire Musculoskeletal Services

Project Lead: Colin Sullivan

Clinician Lead: Dr. Rob Russ

Programme: Planned Care

Will this project impact on OCCG’s ability to deliver the NHS Constitution standards (i.e. four hour A&E, 18 week waits, cancer waiting times, etc.)? Yes

Is this project contradictory to any published best practice guidance (i.e. NICE guidelines)? No

Could this project impact on patient health (i.e. higher infection risk, more frequent patient safety incidents)? No

Does this project discriminate against patients based on any of the protected characteristics? (If so, complete an EIA) No

Could this project negatively impact patient experience (i.e. make patients wait longer, affect patient choice)? No

Describe all of the possible negative impacts on Quality described in the Stage 1 QIA and elaborate on any of the answers where ‘YES’ is stated for the questions above.

Currently the patient experience using the hub has been poor and waiting times have been excessive. We have had individual examples where choice has not been offered as per NHS Constitution however it is hoped that the new system will significantly reduce the likelihood of these incidents occurring.

Mitigating actions to be taken

<table>
<thead>
<tr>
<th>Action description</th>
<th>Responsible person</th>
<th>Time to deliver action</th>
<th>How will you know action is delivered (KPI, survey, audit, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
15.3 Equality Analysis

**Title:** Integrating Oxfordshire Musculoskeletal Services

**What are the intended outcomes of this work?**
Efficient service delivery across all MSK services in Oxfordshire from referral through to follow-up, improving patient experience within cost effective services.

**Who will be affected?**
1. Any changes to the service will only affect patients registered with an Oxfordshire General Practitioner – although OUHT provides a tertiary service for patients registered with General Practitioners outside Oxfordshire.
2. Patients that currently do not use the service but may do so in the future.
3. Staff currently providing services through a fixed location and whose function may change if they are involved in delivery of services in an environment closer to patients’ homes.
4. Staff working in healthcare organisations that currently deliver services from locations that might be impacted by any service being delivered in a significantly different location.

**Evidence**

**What evidence have you considered?** List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.

**Disability** Consider and detail (including the source of any evidence) on attitudinal, physical and social barrier.
According to 2011 census figures across Oxfordshire as a whole, 13.73% of the population either have a disability that limits their day to day activities a little or lot.

Geographically, there is little variance between the districts' distribution of people with a disability. However, there is some variation in the rates for specific age groups across districts, with Oxford (24.7%) and Cherwell (23.2%) containing higher rates among people over 65 than the county average (21.6%).

Figure 1 – Oxfordshire District Disability Comparison

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1. Source: 2011 Census data, Mosaic
According to the 2014 Oxfordshire JSNA, 12,400 people aged 85 and over in households are living with day-to-day activities significantly limited by a health problem or disability. This is equivalent to 49% of the total resident population aged 85 in households.

However, disability free life expectancy is increasing at a faster rate than life expectancy, meaning that not only are people living longer, in the future they might be expected (at the population level) to be living in good health and free of disability for longer towards the end of their lives\(^2\).

A cautionary note is made in the 2014 JSNA in relation to this as such estimates can be skewed by unmet population need and these service level increases might be explained by this factor. The CCG supports the work that is currently underway in collaboration with the London School of Economics to develop more accurate predictive models.

If we are considering future service models that are more prevalent in the community, we need to ensure that all locations chosen offer the levels of access that will continue to provide suitable settings for all with a disability.

Other forms of disability—e.g. sight impairment and hearing impairment will be considered when designing the new service. For the latter, deaf interpreting services will be accessed when needed.

**Learning Disability** Consider and detail (including the source of any evidence) on attitudinal, physical and communication barriers.

National estimates predict that demand for services for people with learning disabilities will increase at a rate between 0.6% and 4% per year between 2009 and 2026\(^2\).
These increases coupled with the general trend of an aging local population will mean that services will be required to work with patients with more complex needs.

The impact of diverting more patients with learning disabilities away from central locations, to those within a community setting will require each facility to be able to deliver an appropriate level of access to the service. As such the CCG will explore the Disclosure and Barring Service (DBS) arrangements with the providers.

**Sex**  
*Consider and detail (including the source of any evidence) on men and women (potential to link to carers below).*

The current and proposed eligibility criteria for access to services do not assess eligibility based on gender.

All service staff are (and will be) trained to respect equality and diversity. Such training is assessed as part of annual mandatory review of all staff and is required within the existing service specification that OCCG holds with the provider of NHS services in Oxfordshire, and will form part of any future service specification for any future providers of this service.

The proposed changes to eligibility criteria should not alter the care provided to such patients and therefore there will be no change to the equality of patients with differing genders.

Some women of particular ethnicity/faith groups may require female only health professional staff, providers should be aware and able, where possible, to accommodate this need.

**Race**  
*Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, language barriers.*

The ethnic composition of Oxfordshire has changed since the 2001 census. All of the county’s black or minority ethnic (BME) communities have grown, and now account for 9.2% of the population and there has been a growth in people from white backgrounds other than British or Irish, who now account for 6.3% of the population (up from 4% in 2001). Much of this increase is explained by a movement of people from the countries which joined the EU in 2004 and 2007.

The figures for other BME communities have similarly grown; people from Asian backgrounds have doubled to 4.8% according to 2011 census figures twice the 2001 figure of 2.4% and the proportion from all black backgrounds has more than doubled, from 0.8% to 1.75% of the county’s population.

The proposals make no distinction based on race. However, this consultation is mindful that there are certain health inequalities in relation to race that may be disproportionately and indirectly impacted on.

Currently staff are trained to respect equality and diversity. Such training is assessed as part of annual mandatory review of all staff and is required within the existing service specification that OCCG holds with the provider of NHS funded services in Oxfordshire. It will form part of any future service specification as services move into community settings, regardless of who provides the service.

In cases where language barriers exist, services will need to access telephony or face-face interpreting services when required. Providing easy read materials can also help, where appropriate. The following link will provide data on households by DC area with members who have English as a first language: [http://insight.oxfordshire.gov.uk/cms/2011-census-data-table-ks206ew-household-language](http://insight.oxfordshire.gov.uk/cms/2011-census-data-table-ks206ew-household-language)

**Age**  
*Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.*

Based on the 2011 Census data and Oxfordshire housing development plans, the population in the county is forecast to grow by 93,000 (14%) between 2011 and 2026, from 655,000 to
Further to this Oxfordshire’s population is forecast to continue aging as seen in the figure below. The proportion of the population that is above the current retirement age (65) is forecast to increase from 16% in 2011 to over 20% by 2026, whilst the proportion that is of working age is forecast to fall.

The rate of growth among these age groups is predicted to be highest in rural areas of the county, with numbers remaining relatively constant in Oxford City.

Figure 2 – Oxfordshire Population Growth Between 2011 and 2026

The impact of the eligibility changes to patients that suffer from long term confusion (of which dementia might be a diagnosis) has been discussed by clinical commissioners.

The impact of diverting older patients away from a central provider location will require us to ensure that safeguarding needs are fully assessed for this group of patients. Future service providers will need to assure the commissioning group around Disclosure and Barring Service (DBS) arrangements.

Whilst older people will be impacted they are also the group who will have the highest needs for accessing the service in any future community-based locations. Arrangements will be made to ensure that no group of patients is negatively impacted by the move to delivery of services in any new locations.

The JSNA evidence suggests that over the next 11 years to 2026 the trend in population growth of the 85 years old and older shows a static growth in the city (5% increase), whereas the county as a whole has rate of increase in the older population of 69%. This would
suggest that services are likely to be located closer to home for many of the population, and proper notice of the accessibility for all individuals will need to be incorporated into any service specification from any provider.

**Gender reassignment (including transgender)** Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.

The current and proposed services do not assess eligibility for access to these services based on gender reassignment. The eligibility will continue to be based on the medical needs of the patient.

Staff are trained to respect equality and diversity. Such training is assessed as part of annual mandatory review of all staff and is required within the existing service specification that OCCG holds with the providers and will form part of the specification in the future for any new (or existing) providers in Oxfordshire.

**Sexual orientation** Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.

The current and proposed eligibility criteria do not assess eligibility for patient services based on sexual orientation. The eligibility is currently, and will continue to be, based on the medical needs of the patient.

Staff are trained to respect equality and diversity. Such training is assessed as part of annual mandatory review of all staff and is required within the existing service specification that OCCG holds with the providers in Oxfordshire.

The proposed changes to eligibility criteria will not alter the care provided to such patients and therefore there will be no change to the equality of patients with differing sexual orientation.

**Religion or belief** Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.

The current and proposed eligibility criteria do not assess eligibility for services based on religion or belief. The eligibility is currently, and will continue to be, based on the medical needs of the patient.

Staff are trained to respect equality and diversity. Such training is assessed as part of annual mandatory review of all staff and is required within the existing service specification that OCCG holds with the providers in Oxfordshire.

It is need which must decide the provision of service. So whilst preference will be respected where possible within the confines of promoting an effective and efficient service, a preference as against an evidence need cannot be guaranteed to be fulfilled by any clinical service.

The proposed changes to eligibility criteria will not alter the care provided to such patients and therefore there will be no change to the equality of patients with religious views or beliefs.

**Pregnancy and maternity** Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.

The current and proposed eligibility criteria do not assess eligibility for services based on pregnancy and maternity. The eligibility for services is currently and will continue to be based on the medical needs of the patient.
Staff are trained to respect equality and diversity. Such training is assessed as part of annual mandatory review of all staff and is required within the existing service specification that OCCG holds with the providers and will continue to form an integral part of any future service in Oxfordshire.

The proposed changes to eligibility criteria will not alter the care provided to such patients and therefore there will be no change to the equality of patients with pregnancy or maternity needs.

**Carers** Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.

Patients requiring an escort or carer to accompany them to any appointment will continue to be offered the opportunity to have someone available.

The current and proposed eligibility criteria do not preclude assess eligibility for services based on the need of a carer. The eligibility for services is currently and will continue to be based on the medical needs of the patient for care.

**Other identified groups** Consider and detail and include the source of any evidence on other groups experiencing disadvantage and barriers to access. (e.g. veterans, homeless people).

The service being proposed does not reduce the equality of access to any part of the service for any group within Oxfordshire. To ensure that this remains a fundamental principle for the commissioning group, service specifications will be written to deliver a service that retains equality of access for all.

The Provider’s Premises will be locally based within close proximity of X-ray, MRI and CT scans where possible and will be within 15 miles radius of patient’s homes. Sites will be available by public transport and have adequate parking.

---

**Engagement and involvement**

How have you engaged stakeholders in gathering evidence or testing the evidence available?

Consultation has taken place with a number of different groups of people representing our protected groups and also with groups representing a wider cross section of the public.

To date, no changes are being proposed that require extensive public consultation under section 244 of the National Health Service Act 2006.

Bodies have been involved since July 2014 and will continue to be involved as we develop the service specification of the service changes being recommended are approved in April 2015.

The service changes have been presented and discussed at various stakeholder meetings, as part of an on-going dialogue:

1. Health Overview and Scrutiny Committee
2. Age UK Health and Social Care Panel
3. Patient advisory groups
4. Clinical advisory groups
5. Local Medical Committee
6. GP Locality Meetings

How have you engaged stakeholders in testing the policy or programme proposals?
The groups listed in the previous section have been engaged during the period July 2014 to March 2015.

Patients (and members of the various bodies) have been keen to direct the provision of services into community environments. All of the caveats listed in the specific protected group sections will be reviewed as the service transitions into the next phase.

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

A process of redesign via engagement with key stakeholders (especially patients, clinicians and health partners) has informed proposed changes to the MSK service that address the complexities inherent within the current system, improve patient experience and reduce unnecessary costs and delays.

A Patient Advisory Group (PAG) and a Clinical Advisory Group (CAG) was established to explore MSK services in Oxfordshire. These groups fed into an overarching MSK project steering group.

Clinical Advisory Group:
This group includes the clinical lead, six GPs representing their respective localities, senior clinicians representing the two main providers (Oxford Health Foundation Trust and Oxford University Hospital) a member of the Local Medical Council and other clinicians as appropriate.

Patient Advisory Group:
This group includes patients and carers with experience of local MSK services invited via Talking Health, locality Patient Participation Groups and the Health and Social Care forum.

Written testimonials sent in by patients who have used the service were also included in this review.

The engagement work with patients and clinicians followed the patient pathway from GP referral through to follow-up.
Oxfordshire Clinical Commissioning Group
Summary of Analysis Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.

There will be no negative, adverse effects for the protected characteristics within the new service redesign for MSK.

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.

Eliminate discrimination, harassment and victimisation
See above
No evidence of discrimination, harassment and victimisation in the current service however the proposed service redesign would address shortfalls in the current service that do not take into account patient’s personal circumstances such as being a carer. This will be support via ‘person-centred care approach’. New and existing staff will be trained in Equality and Diversity.
Providers are required to adhere to section SC13 Equity of Access, Equality and Non-Discrimination in the Standard NHS Contract 2015/16.

Advance equality of opportunity Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).
All people will be treated similarly, unhampered by artificial barriers or prejudices or preferences within the proposed service, whilst acknowledging the differences in some population groups, whose needs will be addressed as described above.
Providers are required to adhere to section SC13 Equity of Access, Equality and Non-Discrimination in the Standard NHS Contract 2015/16.

Promote good relations between groups Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).
All people will be treated similarly, unhampered by artificial barriers or prejudices or preferences within the proposed service, whilst acknowledging the differences in some population groups, whose needs will be addressed as described above.
Providers are required to adhere to section SC13 Equity of Access, Equality and Non-Discrimination in the Standard NHS Contract 2015/16.

What is the overall impact? Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?
The service redesign will not introduce any inequality issues that will impact upon the protected characteristics.

Addressing the impact on equalities Please give an outline of what broad action you are taking to address any inequalities identified through the evidence.
All barriers identified above have been considered and added these under each protected characteristic.
Providers are required to adhere to section SC13 Equity of Access, Equality and Non-Discrimination in the Standard NHS Contract 2015/16.

Action planning for improvement Please gives an outline of the key actions based on any gaps, challenges and opportunities you have identified. Actions to improve the policy/programmes need to be summarised (An action plan template is appended for specific action planning). Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.
The provider is to adhere to section SC13 Equity of Access, Equality and Non-Discrimination in the Standard NHS Contract 2015/16 and implement changes that are proposed in the business case.
Please give an outline of your next steps based on the challenges and opportunities you have identified.

OCCG now has an Equality Reference Group, with members from some of the nine protected characteristic groups, who could be a 'sounding board' for equality issues within the new MSK service. The current methodology of complaints such as PALs at OUH and OCCG Patient Services for when patients experience issues with their treatment.

Name of person who carried out this assessment:
Ceris Challenger
Colin Sullivan

Date assessment completed:
23rd March 2015

Name of responsible Director:
Diane Hedges - Director of Deliveries and Localities

Date assessment was signed:
### 15.4 Impact Assessment

Is there any impact on:

<table>
<thead>
<tr>
<th>Y/N</th>
<th>Comments</th>
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<tr>
<td></td>
<td><strong>Primary care services:</strong></td>
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<tr>
<td></td>
<td><strong>GP services</strong></td>
</tr>
<tr>
<td>Y</td>
<td>Y Self-referral for MSK services estimated to reduce GP referrals by 12% (based on National findings of 50% MSK patients using self-referral) releasing GP and Practice administration time. GPs may feel disempowered due to patients by-passing them. National evidence shows that approx. 50% of patients will still refer via their GP and GPs will be kept informed of patient progress and will have access to patients’ care plan records (with patient consent). GPs will also retain the option of referring complex cases directly to secondary care provided that they take responsibility for the patient’s care planning.</td>
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<tr>
<td></td>
<td><strong>Practice Nurse</strong></td>
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<td>N</td>
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<td></td>
<td><strong>District Nurse Services</strong></td>
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<td>N</td>
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<td></td>
<td><strong>Other community services</strong></td>
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<tr>
<td>Y</td>
<td>Y Primary care physiotherapy and podiatry will operate in a new integrated service with improved sign-posting and communications to facilitate a person centred approach. This is expected to reduce unnecessary appointments, re-assessments, and hand-offs, as well as improve networking and educational work stream.</td>
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<td></td>
<td><strong>Primary care prescribing</strong></td>
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<tr>
<td>Y</td>
<td>Y A Clinical Pharmacist will operate as part of the triage and assessment service, offering advice to clinicians and patients to improve prescribing, compliance and educational work stream.</td>
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<tr>
<td></td>
<td><strong>Secondary care services:</strong></td>
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<td></td>
<td><strong>Out patient activity</strong></td>
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<tr>
<td>Y</td>
<td>Y It is anticipated that a significant volume of trauma, urgent care and post-operative follow-ups will be effectively managed and audited within the community by primary care physiotherapists and podiatrists. An</td>
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APPENDIX A: Communications and Engagement Strategy Report

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Introduction
This brief contains an outline of engagement activity undertaken to support Oxfordshire Clinical Commissioning Group’s Musculoskeletal Services review project.

Background
Musculoskeletal (MSK) services in Oxfordshire are commissioned by Oxfordshire Clinical Commissioning Group (OCCG). One of the largest contracts in MSK services in the county for the Musculoskeletal Triage and Tier 2 Treatment Service is held by Oxford University Hospital NHS Trust (OUHT) and is due to expire in 2016. OCCG is required to develop a commissioning strategy within the next 12 months for an MSK service that is future fit, meets patient need, is efficient and provides a quality service for Oxfordshire patients. To do this we need input from patients, the public and clinicians. The project has been managed in two phases:

1. Phase one: Strategic Outline Business Case (Current state analysis and ‘what constitutes a good service’). Presented to the OCCG Clinical Executives on 23rd September 2014.

As part of the current state analysis OCCG explored feedback from both patients who have used the service, GPs and hospital clinicians. The CCG has also conducted data analysis to understand the current demand for the service and patient and clinician experience. As part of this work OCCG has identified an increasing number of referrals and rising expenditure within the service.

Purpose of engagement
In order to thoroughly consider the future options for MSK services in the county and to support the review project a number of engagement activities were undertaken, including forming a patient advisory group (PAG), clinical advisory group (CAG), joint patient, clinician and stakeholder co-design events to gather feedback on the type, range and standard of services people in Oxfordshire would like to see provided, Experience Based Co-Design (EBCD) to inform the co-design workshops and a public survey.

Process and Methodology
The following engagement activities were run, including:

Patient Advisory Group (PAG)
A Patient Advisory Group was established from the very beginning of the project. An invitation was circulated to patients with experience of MSK services in Oxfordshire within the last two years to join the MSK PAG; via Talking Health (OCCG’s online public consultation tool which has a membership of more than 2,500 Oxfordshire residents), via our locality Patient Participation Groups; via our Equality and Access Commissioners and our stakeholder networks.
The PAG attracted around 16 members, although membership fluctuated over the eleven months of the project and in total 25 patients were involved in the project. Among these members, all are MSK patients except one, who is a carer of an MSK patient. The PAG have nominated a representative who also sits on the Clinical Advisory Group (see below for details) and the MSK Project Steering Group.

Clinical Advisory Group (CAG)
The membership of the MSK CAG includes Clinicians from across OCCG’s localities, those with an MSK specialism and MSK clinicians from provider organisations in Oxfordshire. Both PAG and CAG groups met weekly for four weeks at the start of the project in the summer of 2014 to discuss the MSK pathway, to explore and understand what works well highlight delays, issues and inefficiencies that occur and exist between services and providers as well as discuss what constitutes a good service.

Communications and Engagement Aims
The aims of the communication and engagement strategy were;

- To provide clear, timely information about the need to make changes to Musculoskeletal services in Oxfordshire, to improve patient experience and meet the financial challenges the NHS is collectively facing;
- To provide communications on involvement opportunities to maximise engagement in the project;
- To ensure that feedback from patients, key stakeholders and the public on the current service is captured and opportunities are offered to help shape the future service.
Phase One – Engagement Activity to inform the Outline Business Case
OCCG completed phase one engagement to help inform an outline strategic business case proposal for the future of MSK services in Oxfordshire.

This included establishing a Patient Advisory Group (PAG) to support a Clinical Advisory Group (CAG) where both groups worked to explore MSK services in Oxfordshire. These groups fed into an overarching MSK project steering group.

The PAG met four times during phase one. While the CAG met eight times.

The OCCG MSK project team identified the following opportunities;
- Review of MSK services to ensure value for money
- Improve referral quality to reduce the number of patients who are treated in secondary care
- Make sure care pathways are integrated and efficient
- Maximise opportunities to deliver care in the most appropriate settings

Phase One – Key Findings
Some of the key themes that emerged during the Patient Advisory Group and Clinical Advisory Group meetings were:
- Good quality treatment reported by patients once seen by the appropriate clinician
- Issues with accessing services in a timely manner
- System is confusing for clinicians and patients
- Delays between referral and appointment booking
- Delays between assessment and treatment
- Some patients are not being seen in the right place, first time
- Inefficiencies in communication and exchange of clinical information between clinicians and providers – not integrated
- Need for patient information about care, treatment and care pathway at the outset
- Need for a facility for patients to track their referrals and appointments throughout the pathway.

The feedback gathered during all four PAG meetings was distilled into six key themes. Including:
- communications,
- self and direct referral,
- shared decision-making tools,
- prevention,
- patient centred outcomes and
- the spinal pathway. (It was agreed by the clinicians and project steering group, that if they could use patient and clinician feedback to design and hone the spinal pathway, this would enhance the model for all MSK services.)

The key themes were used as a basis to structure engagement activity during the second engagement phase of the project.
Phase two – Engagement Activity
The next phase of engagement was designed to inform the full business case. Activity was planned to engage patients, stakeholders and the public on key findings and test the plans. Three forms of engagement were undertaken during this phase;
- A public survey on MSK services,
- Three joint patient and clinician events that were held in November 2014, January and February 2015 and
- A patient film was created to inform Experience-Based Co-Design, a process undertaken in parallel with the three events and used with patients and clinicians during the second event.

Public Survey
A public survey was run and posted on Talking Health (OCCG’s online consultation platform). OCCG’s Equality and Access Commissioners also took the survey out to community groups and networks in a discussion group format to get a broad range of views on the survey. The survey aimed to test some of the key findings identified during phase one engagement activity, which included access issues, communication and information issues, amongst a wider audience. The results of the survey provided additional data to support the MSK Project Steering Group and the review into MSK services.

The survey was publicised in the local media, receiving coverage in the Oxford Mail, Oxford Times, the Bicester Advertiser and the Witney Gazette.
For further details on the survey, see the separate MSK survey report.

**Joint patient and clinician events (co-design)**
Three workshops were held, the first on 25 November, the second on 13 January 2014 and the third on 3 February 2015. The workshops involved patients from the PAG, clinicians from the CAG, stakeholders and members of the voluntary sector. Feedback from the events was used to pull together patient experience, clinical expertise and views from voluntary organisations to develop the emerging new MSK service model.

The workshops were structured differently for each session as the project built on the feedback gathered from each event.

The diagram below sets out the different aspects of future state analysis covered at each event.
Workshop one – 25 November 2014
The first workshop focused on MSK co-design focusing on the six themes identified during phase one engagement of the project. Sixty-two people including patients, clinicians and stakeholders attended and were divided into six design groups including: spinal, shared decision-making tools, communications, patient centred quality outcomes, prevention and self and direct referrals. Each group was set objectives and questions to prompt discussions.

The following MSK service model map was shown to illustrate the current state of services:
Following this event the design discussion groups were recognised as constructive and were used again for the second event. Further key issues identified included communications in terms of an IT solution, the importance of a patient-held care plan and prevention throughout the pathway.

**Workshop two – 13 January 2015**

Sixty-five patients, clinicians and stakeholders attended the second event. This event used the same design discussion groups from the previous event to examine six patient films and the resulting experience graph mapped by a small group of patients and clinicians who had volunteered to be part of the Experience Based Co-Design (EBCD) process. Design groups were challenged to examine whether the outcomes identified by their group at the previous event would move patient experience from a negative experience to a positive one.

The EBCD approach was warmly welcomed by both patients and clinicians. A small amount of negative feedback was received about the amount of editing that had been done to the films to fit six patient stories within 20 minutes.

Personalised care plans and communications and IT solutions in particular were the key outcomes of this event.

**Workshop three – 3 February, 2015**

This session, with sixty-four attendees, focused on critiquing the emerging MSK service model. The following image shows the change in structure compared to the previous model and reflects feedback received.
Feedback at the event indicated more time was needed to refine the proposed model. Two focus groups were arranged with volunteers from the third event delegated to a further session on care planning and a further session on the model itself.

**Person-centred care planning focus group – 3 March 2015**

Eleven people attended this session including patients, voluntary sector representatives, clinicians and health service managers. Feedback gathered included;

- involving the voluntary sector in a more central support role within the model and
- that personalised care planning should be initiated at the first appointment with a clinician,
- that stratification is required to determine who has a care plan and if a plan is appropriate, it should stay with the patient throughout their care.

Twenty clinicians and two patients attended a session to further critique the above model and refine the model for submission within the full business case.

The feedback from all three workshops and subsequent two focus groups was incorporated into the development of the MSK services model and full business model that is to be submitted to OCCG executives in April.

The full feedback from the three workshops is included in Appendix 2.

**Experience Based Co-design**

The CCG also recruited local MSK patients to be filmed talking about their patient experience. Each patient was filmed for around 20 minutes. These individual films were edited to capture the key points that each patient made. The films were then edited together to ensure there was information captured on film about the whole pathway from referral through to treatment and follow-up care using the different patient stories. The final film was then edited to around 20 minutes to ensure it was a suitable length to be used during one of the forthcoming joint patient and clinician events.
The films were then used as part of an experience based co-design (EBCD) approach (involving patients and clinicians) within the design methodology. Members of the PAG and CAG were approached and invited to be part of a small working group examining the film and using the ECBD approach. A group of fifteen met, viewed the film and noted their emotive reactions of points made by patients at points throughout the patient pathway.

The emotive points were then mapped on a graph. The results on the graph mirrored the feedback received throughout previous engagement activities. It revealed positive experiences for patients when first seen and referred by their GP and when treated for their condition. However the stages of care in between referral and treatment were more negative and was called ‘the banana diagram’ after the negative curve represented. The resulting graph was then presented at the second joint patient and clinician event following a showing of the patient film. Delegates at the event were then asked to test the developing new service model and whether it would change the issues identified by the EBCD approach from a negative experience to a positive experience.

**Key Findings**

All events were well received by the individuals that attended and it was recognised that most patients were reporting good quality care, once they were seen by the right clinician. Issues arose in their journey to getting seen and treated by the right clinician. The purpose of this review and co-design approach is to ensure that the care experienced by MSK patients is of a high standard from their first contact with MSK services.

The biggest issues were communications between clinicians and between clinicians and patients, with IT solutions repeatedly being put forward by both patients and clinicians.

**Communications**

This theme has been a dominant theme throughout the project and emerged in a full room debate on the model presented during the third workshop. Issues included:

- Not enough detail in the model to show how communications would be improved
- Patients not aware of where they are in the system
- Proactive communications not reactive, clinicians and patients want oversight of care
- Reliant on information being received. An IT solution needed with access for all appropriate.
- Health literacy, patients want information to be enable them to self-care
- Care planning is key
- Care co-ordinators needed so patients have a point of contact to refer to.

Throughout the engagement activities, patients reported receiving good quality care when they were seen and treated. Feedback and findings listed above describe solutions identified during phase two engagement to address process and system issues identified by patients and clinicians. The list above describes the more proactive role patients would like to be able to adopt to have more of an understanding of their care.

**Next steps following this engagement project**

The themes and feedback from all engagement activities listed in this report have been fully considered in developing the model for future MSK services in Oxfordshire and in putting together a full business case.

This engagement report will be appended to the full business case. This report will be shared with all those who participated in this engagement activity. The report will also be made available on OCCG’s Talking Health website at: [https://consult.oxfordshireccg.nhs.uk](https://consult.oxfordshireccg.nhs.uk)
Evaluation
The level of engagement of patients in the project has received praise from patients, patient locality forum members and clinicians.

Qualitative feedback
The following anecdotal anonymous feedback has been received:
- ‘This project has really involved patients’
- ‘I feel my views have really been listened to’.

Quantitative feedback
During the project a total of 25 patients were engaged in various activities, although not all patients participated in all.

The survey, which was posted on Talking Health, OCCG’s online consultation platform, attracted 128 registered users to become members of the consultation and 89 people went on to complete the survey. The survey was also taken out in discussion group format to community groups by OCCG’s Equality and Access team and attracted 58 responses via this method.

Appendix 1: Survey report and supporting appendices
Appendix 2: Full feedback from the three joint patient and clinician events

Author: Annie Tysom. Date: 2 April, 2015
## APPENDIX B: Estimates of Third Sector Support

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Contact</th>
<th>Services supporting MSK patients</th>
<th>Ball Park Cost (£s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Here for Health,</strong></td>
<td>Áine Lyng</td>
<td>Here for Health can offer the following service for MSK patients;</td>
<td>Approx 30k per member of staff recruited + 2k for leaflets and resources.</td>
</tr>
</tbody>
</table>
| Level 2, John Radcliffe Hospital, Headley Way, Oxford, OX3 9DU | Health Promotion Specialist 01865 221429 Aine.Lyng@ouh.nhs.uk | - Patients to be sign posted from secondary care consultants, GPs, media, promotion, and website to the Here for Health centre.  
- Act as the link between third sector and MSK patients. Sign post patients to relevant community services.  
- Can expand service with extra members of staff, undertake training on how to advise MSK patients and incorporate the care planning element.  
- Health Improvement Practitioner is a band 5 and would cost approximately £30k.  
- Can undertake training to be able to advise MSK patients, including the care planning training for practitioners within the MSK service.  
- Can provide a ‘pop up’ service within the different MATT sites providing members of staff are able to be recruited. |                                                                                  |
| **Oxfordshire Sports Partnership,** | Jenny Shaw 01865 252606 jshaw@oxfordshireesport.org www.oxfordshiresport.org | Oxfordshire Sports Partnerships can offer the following services for MSK patients;  
- ‘Go Active get healthy’ offers a tailored programme to people looking to get fit.  
- Physical activity features heavily the prevention management with conditions  
- Motivational coaching is included in the service  
- Be on public website and contribute to content  
- Specific activities for patients with MSK conditions  
- Physiotherapists already refer to into the programmes offered and there are intentions to work together with physiotherapists to discuss activities for patients with MSK conditions for example Pilates and yoga etc. being good for strengthening.  
- The services are provided locally in Oxfordshire.  
- They are eager to establish some key consistent messages around physical activity throughout the pathway.  
- The programme is currently tailored to the individual and they can work with the patient on their MSK care planning – and already include goal setting in the programme.  
- They currently have the capacity to take on large volumes of patients until March 2016 as funding is secured until then. | Funded until March 2016. Service costs approximately 160k per year. Any contribution to funding would be hugely beneficial to keep service running as funding to continue the service is currently being sought for another 2 years. |
APPENDIX C: Project Plan

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Review impact assessments</td>
<td>23rd</td>
</tr>
<tr>
<td>4. Gather intelligence and costing for IMBT solutions</td>
<td>26th</td>
</tr>
<tr>
<td>5. Test service model with wider GP population by</td>
<td>28th</td>
</tr>
<tr>
<td>6. Build costing model</td>
<td>1st</td>
</tr>
<tr>
<td>7. Data analysis of current activity to inform final</td>
<td>17th</td>
</tr>
<tr>
<td>8. Cost changes</td>
<td>25th 1st</td>
</tr>
<tr>
<td>9. Prepare finance case</td>
<td>1st</td>
</tr>
<tr>
<td>10. Prepare funding</td>
<td>27th</td>
</tr>
<tr>
<td>11. Draft full business case</td>
<td>30th</td>
</tr>
<tr>
<td>12. Review Business Case</td>
<td>1st</td>
</tr>
<tr>
<td>13. Final amendments to business case</td>
<td>1st</td>
</tr>
<tr>
<td>14. Submit full business case</td>
<td>1st</td>
</tr>
<tr>
<td>15. Full business case approval</td>
<td>2nd</td>
</tr>
<tr>
<td>16. Work up specification with</td>
<td>3rd</td>
</tr>
<tr>
<td>17. Contracting with existing Providers</td>
<td>3rd</td>
</tr>
<tr>
<td>18. Mobilisation</td>
<td>3rd</td>
</tr>
<tr>
<td>19. GO LIVE</td>
<td>3rd</td>
</tr>
<tr>
<td>20. Procurement documentation</td>
<td>3rd</td>
</tr>
<tr>
<td>21. Invitation to tender</td>
<td>3rd</td>
</tr>
<tr>
<td>22. Evaluation</td>
<td>3rd</td>
</tr>
<tr>
<td>23. Award contract and standstill</td>
<td>3rd</td>
</tr>
<tr>
<td>24. Mobilisation</td>
<td>3rd</td>
</tr>
<tr>
<td>25. GO LIVE</td>
<td>3rd</td>
</tr>
</tbody>
</table>

- CCG Execs meeting: 24th
- Portfolio Management Board: 25th
- Clinical Ratification Group: 3rd
- Joint BPP: 3rd

Go Live: May 16
APPENDIX D: Details on Option B Integrated MSK Model

The Case for Self-referral

The national ‘Your health, your care, your say’ public listening exercise in 2005 indicated support for self-referral to allied health professions AHP services, and the resulting White Paper included the following commitment:

‘...in order to provide better access to a wider range of services, we will pilot and evaluate self-referral to physiotherapy. We will consider the potential benefits of offering self-referral for additional direct access for other therapy services.’

Self-referral to AHP services is not a new concept. Physiotherapists (and other AHPs) have been able to act as first-contact practitioners since 1978. The Department of Health (2008) reported that self-referral is well established in the independent sector and is used in the NHS but is not ‘universal’, so there is inconsistency in the system.

The Department of Health (2008) worked in partnership with six sites and the Chartered Society of Physiotherapy (CSP) to pilot self-referral to musculoskeletal physiotherapy. Demographic and clinical data relating to the population from the pilot sites was collected and analysed with the following findings:

- High levels of service-user satisfaction and confidence.
- A more responsive and attractive service to patients with acute conditions, affording them wider access.
- Empowering patients to self-care/ self-manage in order to meet their needs.
- Lower levels of work absence.
- No increase in demand for services.
- Accessed by males and females of all ages.
- No evidence that BME groups use self-referral less than white groups.
- Greater levels of attendance and completion of treatment.
- No return to the NHS by patients traditionally seen within the private sector.
- Well accepted and supported by physiotherapists and GPs.
- Associated with lower NHS costs.
- 75% of patients who self-referred did not require a prescription for medicines.

Among patients who self-referred during the pilots:

- 77% were satisfied or very satisfied with being able to self-refer
- 59% preferred a community setting as the location for assessment/treatment
- 65% preferred to be able to make an appointment to see the physiotherapist without having to see their GP first
- 72% were confident that they knew when they needed to consult a physiotherapist;
- 74% thought that patients can learn a lot about how to manage their conditions themselves
- 89% would use the service again
- <1% regularly used private providers, and fewer than 24% had ever used a private provider.
The vision
People with musculoskeletal conditions can access high quality, effective and timely advice, assessment, diagnosis and treatment to enable them to fulfil their optimum health potential and remain independent. This will be accomplished through systematically planned services, based on the patient’s journey and with integrated multidisciplinary working across the health economy.

Care pathway
• Information and education
• Access to high quality front line care
• Ensuring appropriate access to a range of specialist opinion
• First line specialist opinions in musculoskeletal CATS
• Pre-listing clinical assessment
• Listing for surgery
• Pre surgical assessment
• Outpatients follow up after surgery

The following problems are apparent
• Poor patient experience
• Failure to undertake holistic multidisciplinary assessments of patients’ support networks
• Poor advice and support in managing pain at all points along the patient’s journey
• Large number of long waits
• Inequity in provision and access
• A shortfall in tailored services in child and adolescent practice
• A lack of clear integrated care pathways
• Lack of timely and complete patient information at appropriate points along the patient journey

The Audit Commission considers the creation of Clinical Assessment and Treatment Services (CATS) through service redesign as of great strategic importance.

Shared care across primary and secondary care should significantly contribute to a reduction of hospital admissions, and all Rheumatology services should be part of clinical networks

A front line physio can see 500 new patients annually working on a one new and four follow up appointments

An ESP will see 300 new patients per year – they have to have time to do training of the more junior staff plus the triage

Cognitive behavioural intervention
The cost per Quality Adjusted Life Year (QALY) for bespoke cognitive behavioural intervention package for low-back pain has an important and sustained effect at one year on disability from low-back pain at a lower cost to the health-care provider. Cognitive behavioural intervention (£1786) is substantially lower than that of competing interventions for low-back pain. Estimates of the incremental cost-effectiveness ratio for acupuncture, exercise, manipulation, and postural approaches are £4242, £3800, £8700, and £3090, respectively.
The Case for the Person-Centred Care Approach

Introduction
The NHS Five Year Forward View sets out the vision for the future NHS including a new relationship with patients and communities that supports people to gain far greater control of their own care when they need health services. Personalised care and support planning will be a key part of this shift. While not a new concept, it is increasingly important to recognise the assets and value that patients, carers and communities can bring to help deliver more effective, person-centred and sustainable care for people with long-term conditions (NHS England 2015).

Personalised care and support planning is an essential prerequisite for helping people living with long term conditions. It transforms their experience from a largely reactive service, which responds when something goes wrong, to a more helpful proactive service, centred on the needs of each individual patient (NHS England 2015).

Evidence shows that personalised care and support planning can lead to the most appropriate use of limited healthcare resources. People who are engaged in their health and care are more likely to receive care and treatment that is appropriate to them; to take up appropriate prevention services (such as regular screening); and to adopt more healthy behaviour. By sustaining successful self-management, and by anticipating and making explicit provision for possible crises and emergencies, personalised care and support planning may also help to reduce the use of urgent and emergency care (NHS England 2015).

Person Centred Care within the proposed MSK service
Within the proposed MSK service, person centred care will include a public self-management advice website and an online care planning tool which will include within it; shared decision making aids, links to voluntary organisations and their services, quality patient outcomes with advice on how to self-manage their condition within a care plan.

Within OCCG’s stakeholder engagement for the musculoskeletal service redesign, five cross sectional areas were identified to be addressed within the new model. These were; prevention, communications, shared decision making, quality patient outcomes and self-referrals. The personalised care approach can incorporate elements of all five.

Prevention – intelligent selection of voluntary organisations, with the patient in mind, will aid secondary prevention. Links with the third sector should be made clear on the public website and within the care planning tool as early as possible in the patient journey. Healthy lifestyles should be actively encouraged for every patient within the care planning tools, the website, and the pathway.

The patient website should be put together by Oxfordshire hospital consultants, GPs, physiotherapists and clinicians with a special interest in managing musculoskeletal pain representing their agreed approach to managing patients in Oxfordshire with common conditions affecting the joints, muscles and surrounding tissue and take into account the latest national and international best practice guidelines on pain management. It should be used in conjunction with advice given by the GP, physiotherapist or specialist. The website should be designed as a one-stop advice site for people in Oxfordshire to find out about musculoskeletal pain, how they can manage it and what they can do to prevent further problems.

Patient communication – the care planning tool should provide information on who the patient should contact, if necessary, as well as a method for the clinician to contact the patient via the care planning tool. The public website will also allow patients to be fully informed on
the services provided in Oxfordshire. There should also be a log/journal section in the care planning tool for the patient to make notes on their condition that the clinician is able to view.

**Shared decision making** – shared decision making aids should be included in the care planning tools and the public website for patients to access. Patient Decision Aids are specially designed information resources that help people make decisions about difficult healthcare options. People's views change over time depending on their experiences and who they talk to and this is a vital part to include within the personalised care approach.

**Quality patient outcomes** – patients will identify, along with clinicians, the patient’s outcomes/goals which will be recorded in the care planning tool.

**Care planning** - Care planning can enable people to self-manage their condition, and to identify actions they can take to improve their own health. During care planning, people discuss their full range of needs with one or more health professionals and with their family and carers, and identify and set out goals. Care planning can enable people to self-manage their condition, and to identify actions they can take to improve their own health. During care planning, people discuss their full range of needs with one or more health professionals and with their family and carers, and identify and set out goals (Arthritis Research UK, 2015). This will need to be facilitated by an online care planning tool that a patient and clinician can access.

**What are the incentives and drivers to deliver personalised care and support planning, how does it fit with other initiatives?**

Evidence shows that personalised care and support planning can lead to the most appropriate use of limited healthcare resources. People who are engaged in their health and care are more likely to receive care and treatment that is appropriate to them; to take up appropriate prevention services (such as regular screening); and to adopt more healthy behaviour.

The importance of person-centred care, support for self-management and personalised care planning has been highlighted in numerous policy documents over the past decade;

- The NHS Constitution includes the right “to be involved in discussions and decisions about your health and care, including your end of life care, and to be given information to enable you to do this. Where appropriate this right includes your family and carers.” And also the commitment “to involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one”.
- The NHS Mandate includes the commitment that by 2015 “everyone with long-term conditions, including people with mental health problems, will be offered a personalised care plan that reflects their preferences and agreed decisions”.
- The NHS Standard Contract specifies service conditions related to personalised care planning and shared decision making (SC10).
- The National Collaboration on Integrated Care and Support, which includes the Department of Health, NHS England, and the Care Quality Commission, published Integrated Care and Support: Our Shared Commitment which outlines commitments at a national level and expectations of local areas.

**Benefits to people with long term conditions**

- Involvement in decisions about their care.
- A better understanding of their condition.
- Respect for and recognition of their everyday work to self-manage.
- Tailored support to increase confidence and skills in self-management.
• Consistency and continuity of care – the person with the condition is the most consistent provider of their own care.
• A central role in service planning and agreeing what local care should look like.
• Information and signposting to local support services.

Benefits to clinicians
• More satisfying consultations.
• Commissioning influenced by genuine clinical data.
• Services commissioned that people with LTCs will use.
• Better outcomes for people with LTCs.
• A new and interesting skill set.
• A lever to improve clinical IT and drive quality improvement.
• Less inappropriate use of medication

Benefits to commissioners
• Greater value for money, as services provided meet individual needs, deliver improved health outcomes and reduce medicine wastage.
• A positive impact on other local and national drivers, such as reducing acute admissions and improving the patient experience.
• Complete fit with QIPP.
• Provides information needed to commission services that people want and clinicians' value.
• A detailed understanding of pathways and costs as the basis of new local currency
• A stimulus to the whole healthcare community to redesign services for LTCs, ensuring the right care is provided, in the right place, at the right time, by people with the right skills, with the right funds.
• Provides a long term, sustainable approach to reducing the burden of LTCs on local resources.

References
APPENDIX E: Pathways for Option B Integrated model

Promotion of self-management

If a member of the public develops aches or pains, or is an existing patient with known and treated MSK condition they can be directed to access the musculoskeletal ‘aches and pains’ website.

Website to be actively promoted especially by the Musculoskeletal Assessment, Triage and Treatment Service (MATT) GPs and Third Sector.
INFLAMMATORY AND NON-INFLAMMATORY ARTHROPATHY

Notes on pathway:
1. Current state does not align with current guidelines.
2. GPs will not have direct access to the EIA clinic. Research shows that effective triage prevents up to 50% of patients not requiring attendance at an EIA clinic from doing so and does not increase the delay for those who should be there.
3. Rheumatology interface meeting will be available weekly (some weeks it may not be required but the option will be there). Rheumatology triage currently takes place weekly. The proposed improvement is that discussions (virtual or face to face) about the cases should occur rather than passing written information back and forward.
4. Bloods are used to define the treatment options once an EIA has been diagnosed to inform the diagnosis. Old records and history may be sought for a variety of reasons but should not delay the process.
5. Patients with an inflammatory arthritis, in remission, will be discharged from the EIA clinic, and needing a long-term care plan to manage monitoring of their long-term treatment, relapse recognition and strategies. The MATT will provide the ongoing support, via care planning and advice on self-management.
6. Shared care for DMARDS as per APCO agreement.
BACK PAIN PATHWAY
MSK redesign aligned with the Pathfinder spinal pathway for back pain

The box numbers correspond to the Pathfinder lower back pathway Greenough C.G, December 2014 National Pathway of Care for Low Back and Radicular Pain, NHS England London
RADICULAR BACK PAIN PATHWAY
MSK redesign aligned with the Pathfinder spinal pathway for back pain

[The box numbers correspond to the pathway numbers from the Pathfinder pathway for low back and radicular pain.]

Greenough C G (December 2014) National Pathway of Care for Low Back and Radicular Pain, NHSE England London
APPENDIX F: draft Service Specification
Please see service specification attached.
APPENDIX G: IM&T Service Specification for MSK redesign

Introduction

• This document aims to capture the information requirements identified during the consultations for the redesign of the MSK referral and treatment pathways, and is intended to contribute the overall business case
• Information Management and Technology (IM&T) solutions are seen as enablers to transformational change. Their selection and deployment must be part of the transformational process, and will require appropriate resource.

Context:

• The information requirements of MSK services must be aligned with and contribute to the requirements of:
  o The Oxfordshire county-wide IM&T strategy, to be published later in 2015
  o The OCCG IM&T strategy, currently managed by the IM&T programme board

1. Assumptions

   a. System-wide fit
      ➢ MSK solutions will be able to be applied to other pathway requirements at a cost and pace acceptable to OCCG.

   b. Clinical information sharing
      ➢ Clinical information sharing between organisations will be achieved using OCCG-approved systems, such as the Oxfordshire Care Summary and the Electronic Document Transfer hub. Additional processes for sharing information will meet IG and clinical safety requirements and will be in line with the OCCG IM&T strategy.

   c. Clinical content
      ➢ Where clinical content is required (such as website information, clinical forms or clinical data sets) the content is agreed, approved and reviewed by specified clinicians, managers and commissioners according to an agreed process.

   d. Sharing and use of personal data
      ➢ Citizens are clearly informed about their choices and the benefits and risks of sharing personal data.
      ➢ Citizens are able to choose what data they share with whom, and to nominate proxies to assist them.
      ➢ Citizens are able to choose whether their personal data is used for clinical care, for health care analytics, or medical research.
e. Business continuity
- Processes are in place for citizens who are unwilling or unable to use electronic information.
- Processes are in place for when electronic systems fail, for whatever reason.

f. Existing systems
- An integrated MSK solution makes best use of existing systems where they exist

2. Procured functionality integrates with existing systems and new processes are developed to provide a seamless experience for the citizen and for professional users.

Requirements:

a. Function: information
- Up-to-date information about all aspects of MSK is available via a public website, including:
  o Medical information
  o Local resources
  o Pathway information
  o Links to third sector programmes
  o Advice on diet and exercise

b. Function: self-assessment
- Citizens are able to self-assess their MSK requirements, using locally agreed assessment criteria and evidence from other sources, such as approved apps
- Information from self-assessment forms is structured (fielded or coded) to allow integration of records
  i. Levels of sharing (controlled by the citizen)
    ✓ Self-assessment can be completed anonymously and not stored.
    ✓ It can be completed and stored as part of a Personal Health Record, referred to in this document as MSKphr.
    ✓ It can be completed, stored and shared within a personal network
    ✓ It can be completed, stored and shared with a clinical network (including OCS)

c. Function: self-management
- Citizens are able to make decisions about their self-management based on their self-assessment (5b), and linked to information available as in section (5a)
- Citizens are able to set goals and make plans for self-care based on their self-assessment (5b) and the information available in section (5a)
- Information from self-management processes is structured (fielded or coded) to allow integration of records
i. Levels of sharing (controlled by the citizen)
- Self-management processes can be completed and stored as part of an MSKphr
- They can be completed, stored and shared within a personal network, member of which may also contribute to the plans
- They can be completed, stored and shared with a clinical network (including OCS), members of which may also be able to contribute to the plans
- They can contribute to health analytics and medical research

d. Function: self-referral
- Citizens can register for local initiatives for self-management.
- Citizens can refer themselves to the MSK SPA using an electronic form, and receive an acknowledgement that the referral has been received.
- The sending of the referral creates a trigger to indicate that the pathway has started.
- This information may be available to the OCS later on the process.

i. Levels of sharing (controlled by the citizen)
- Self-referrals / registrations can be completed as a stand-alone process
- Self-referrals / registrations can be completed with evidence from the self-assessment process
- Self-referrals / registrations can be completed with evidence from the self-assessment process and stored in an MSKphr
- Self-referrals / registrations data may be used for health analytics and medical research

e. Function: GP referral
- The GP is able to locate and send the appropriate electronic referral form.
- Information will be available from this process (from GP system or DXS) to create a trigger to indicate that the pathway has started.
- This information is available to the OCS and to an MSKphr where available.

f. Function: other provider referral
- Other providers are able to locate and send the appropriate electronic referral forms
- Referrals are recorded in the provider system; the information will be used to create a trigger to indicate that the pathway has started
- This information is available to the OCS and to an MSKphr where available

g. Function: Referral Assessment and Sign-posting Service (RASS)
- The RASS process automatically creates a trigger to indicate that the referral has been received, and another one to indicate when a referral has been triaged.
- This information is made available to the OCS, and to MSKphr, where available.
- SPA clinicians will have access to the OCS and information from the self-assessment, if available.
- Information they record will be available to the OCS, and to an MSKphr, where available
h. Function: appointments
- The allocation of an appointment automatically creates a trigger
  - This information is available to the OCS and to an MSKphr, where available

i. Function: diagnostics, assessment, treatment, transfers of care and outcomes (MATTs)
- Provider systems are able to record diagnostics, clinical assessments, treatments and the complete personalised care-planning package
- Defined data sets are shared with the OCS, and with an MSKphr where available
- The MATTs service is able to request diagnostics and review and share results within an acceptable time frame
- Clinicians are able to contribute to the citizen’s self-management plans (they will be able to assist the citizen to create one, if they haven’t already done so) in order to undertake collaborative care planning.
- Processes are agreed to manage data entry into self-management plans and clinical systems
- Clinicians are able to manage the lists of plans they are contributing to and are able to receive and respond to alerts and messages within the self-management system.
- Clinicians are able to share transfers of care information with the citizen’s personal and clinical and social care networks as, appropriate
- Transfers of care create a trigger which can be shared with the OCS or an MSKphr where available
- **Outcomes** are measured using the self-assessment / self-management processes
  - Person Identifiable Data from assessments, treatments, transfers of care and outcomes can be used for health analytics and medical research, as specified by the citizen

j. Function: notifications
- Notification requirements such as letters, texts and emails have been identified, and their content agreed.
  - Workflow processes have been agreed to ensure these are sent as specified, or
  - Workflow management software has been deployed to enable these to be managed automatically in response to triggers described above

3. Next steps
- Map function processes
- Identify how functionality can be achieved using:
  - Existing systems
  - Existing systems with enhancements
    - Attention should be paid in particular to the current and potential functionality of DXS and Choose and Book
  - Procurement of new systems to enhance existing systems
  - Commissioning of services
- Agree minimum requirements for go-live
- Agree road map for additional functionality
APPENDIX H: Calculations for Demand on Proposed Service Model

To calculate required demand (number of referrals) for the new MSK service model

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<thead>
<tr>
<th></th>
<th>Initiated episodes of care</th>
<th>Total activity</th>
<th>First to follow-up ratio</th>
<th>Number firsts</th>
<th>Number follow-ups</th>
<th>Total Referrals</th>
<th>Total cost firsts and follow-ups</th>
<th>Data source</th>
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<tbody>
<tr>
<td>GP Direct Access Physiotherapy (OHFT)</td>
<td>13697</td>
<td>N/A</td>
<td>1:2</td>
<td>7945</td>
<td>14182</td>
<td>2424</td>
<td>£1,891,335</td>
<td>OHFT CSC Quality Report 2013/14</td>
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<td>GP Direct Access Physiotherapy (OUHT)</td>
<td>22127</td>
<td>1:1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SUS FY 2013/14</td>
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<tr>
<td>Primary Care Podiatry (OHFT)</td>
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<td>1:1</td>
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<td>2363</td>
<td>2424</td>
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<td>Sub-totals</td>
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<td>16545</td>
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<td>£2,822,530</td>
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<th>Initiated episodes of care</th>
<th>Total activity</th>
<th>First to follow-up ratio</th>
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<th>Number follow-ups</th>
<th>Total Referrals</th>
<th>Total cost firsts and follow-ups</th>
<th>Data source</th>
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<td>GP Direct Access Physiotherapy (other)</td>
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<td>Estimate activity for Practice based physio. Actual Costs 2014/15</td>
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<td>Primary Care Podiatry (Montgomery)</td>
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<td>£108,000</td>
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Total referrals 24498

Staffing costs from activity based costing model (based upon 2014/15 AFC)

Notes
Using activity based costing model optimistic set to lowest clinical tolerances on all parameters and pessimistic to highest
Based on 1400 working hours/ annum for whole time equivalence

With 'no' diversion of surgical procedures to the MATT service
Total staffing costs of service
- Pessimistic £3,914,698
- Expected £2,625,900
- Optimistic £1,523,027

With diversion of 10% surgical procedures to the MATT service
Total staffing costs of service
- Pessimistic £4,012,781
- Expected £2,691,692
- Optimistic £1,561,186

With diversion of 20% surgical procedures to the MATT service
Total staffing costs of service
- Pessimistic £4,110,864
- Expected £2,757,484
- Optimistic £1,599,346

Notes
Assume number of firsts = number of referrals
Number of referrals for GP Direct Access Physio (OHFT) = number initiated episodes of care
Number of referrals for GP Direct Access Physio (OUH) = Number of firsts
Appendix I: Estimates for Information Management software solution

Costing estimates for the IM&T:
   A) Map My Health (private Healthcare/Software Co.):
      -Initial development costs estimated at £120-150K (all inclusive)
      -License estimated at £120k/ annum to cover hosting, support, operational costs and maintaining the system

   B) Looking Local (not-for-profit Kirklees Council):
      -Initial development costs year one £88 + VAT
         Year two £44k + VAT/ annum to cover hosting only
      -License at zero cost
APPENDIX J: Facilitating contractual elements

The proposed service model (with draft service specification) has been designed to address the inefficiencies and lack of integration inherent within the current musculoskeletal service, to facilitate the following elements of the Standard NHS contract for community physiotherapy services:

<table>
<thead>
<tr>
<th>Relevant contractual elements of the NHS contract for community physiotherapy services</th>
<th>How the element will be facilitated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service objectives</strong></td>
<td></td>
</tr>
<tr>
<td>➢ To provide an accessible service for clients, this includes self-referral.</td>
<td>Self-management website gateway into self-referral</td>
</tr>
<tr>
<td>➢ To provide community services that have strong emphasis on patient education and self-management, thereby promoting active, healthy lifestyles and reducing recurrence of injury or illness</td>
<td>Person centred service with care planning. Networking with third sector and ancillary services. Integrated information management and technology.</td>
</tr>
<tr>
<td>➢ To deliver a person-centred service that is integrated with all agencies involved with the patient.</td>
<td>Integrated one stop shop Musculoskeletal Assessment Triage and Treatment Service co-located with x-ray and other scanning diagnostics where practicable to do so.</td>
</tr>
<tr>
<td>➢ To provide a holistic, one-stop (where appropriate) service for patients</td>
<td>Redesigned pathways based around a core one stop shop, triage, assess and treatment service networked with all involved agencies. Person centred approach with patient centred outcomes.</td>
</tr>
<tr>
<td>➢ To deliver safe, evidence based care</td>
<td></td>
</tr>
<tr>
<td>➢ To deliver the shortest pathway possible that is compatible with best outcomes for patients</td>
<td></td>
</tr>
<tr>
<td><strong>Operational Outcomes</strong></td>
<td></td>
</tr>
<tr>
<td>➢ The timely assessment and delivery of care</td>
<td>Extended Scope Practitioners triage and sign-post to the right clinician, right place and right time, facilitated by true integration with primary care community therapies, ancillary services and secondary care.</td>
</tr>
<tr>
<td>➢ Delivered in an integrated approach with other health care services</td>
<td>Bespoke integrated systems to produce care plans accessible to all involved agencies and the patient</td>
</tr>
<tr>
<td>➢ The production and maintaining of comprehensive care plans</td>
<td></td>
</tr>
<tr>
<td>➢ Reduce reliance on primary care consultation</td>
<td>Self-referral into the MATT service</td>
</tr>
<tr>
<td>➢ Reliance on secondary care services reduced</td>
<td></td>
</tr>
<tr>
<td>➢ A reduction in avoidable admissions to long term care</td>
<td>Primary/ Secondary care interface meetings and collaborative working Shortest possible pathway to ensure timely appointments and reduced risk of exacerbation of conditions (e.g. inflammatory Rheumatoid Arthropathy)</td>
</tr>
</tbody>
</table>
Appendix K
Oxford University Hospitals Trust response to OCCG proposals

Response to ‘Integrating Musculoskeletal Services’ paper from OCCG - Orthopaedic Directorate – Karen Barker 16/04/2015 MSK Hub response

The OUH has been fully engaged in working with the CCG to review and improve MSK services. A number of representatives from the Directorate have attended a series of workshops and meetings with the MSK steering group to assist in informing the development of Oxfordshire MSK services. However, there were a number of different organisations and stakeholders who equally contributed and as such there are a number of things in the document which do not accord with the Orthopaedic Directorate viewpoint.

The document was discussed in detail by all lead consultants associated with Orthopaedic and Rheumatology Services and current hub staff. Representatives were:

- Mr Chris Little – Upper limb consultant lead
- Mr Adrian Taylor – Hip & Knee consultant lead
- Mr Mark Rogers – Foot and Ankle lead
- Mr Martin McNally – Limb Reconstruction / infection current hub lead clinician
- Dr Natasha Jones – Sports Exercise Medicine – Musculoskeletal Physician
- Dr Kassim Javaid – Rheumatology lead
- Mrs Elaine Buchanan – Consultant Physiotherapist
- Mr Paul Horwood – Orthotics lead clinician
- Professor Karen Barker – Clinical Director Orthopaedic Directorate; lead for MSK hub.

We have not provided a detailed response, but highlighted key areas for clarification or of concern.

1. The paper gives no justification or explanation for not exploring Option 1; it states that this would not improve patient experience, generate savings and is unsustainable; yet proposes an untried or tested alternative.

2. Very precise guidelines and enforcement of the pathway for GPs to refer urgent cases direct to Secondary care would be needed to avoid this being used to by-pass the RAS / MATT services. Our experiences are that in both spinal and Rheumatology the GPs perception of Urgent is often very different to the Secondary Care view.

3. It does not appear that the new pathway has fewer steps as asserted (p15), just different ones with less GP involvement.

4. There would need to be careful consideration given to the competencies of interface staff. It would be inappropriate to use junior doctors and SpR grades, who have to work under the supervision of Consultant staff and who would lack the competency to carry out this role unsupervised. We are also concerned that there would not be GPSIs available to be recruited to work in the service.

5. It is unclear why the urgent pathway includes surgery and paediatrics; but not rheumatology and infection.

6. We believe that the assumption that the new model will be more cost effective than the existing hub model is very optimistic and that there is a significant risk that referral for diagnostics and onward referral to secondary care may increase [currently a considerable amount of ‘free’ expert opinion is gained by informal discussions between secondary care consultants and hub clinicians that prevents referral]

7. Under the existing hub model; patient feedback is consistently good. GP feedback, however, is mixed. One of the key reasons that GPs do not support the hub is because...
their referral does not go to the clinician of their choice directly. This situation is likely to be perpetuated and inflamed by the proposed design.

8. The model does not show where the Choice of Provider for Secondary care fits in, when or how offered and onward referral managed.

9. Pain rehabilitation – Optimise should remain a secondary care specialist service. Any provider of primary care physiotherapy should provide psychologically informed physiotherapy using evidence based protocols such as BEST programme (designed to be delivered in primary care).

10. Only a proportion of patients will be able to transfer for follow up in the MATT from secondary care. For others, follow up is an important part of their therapeutic journey and outcome to initial treatment needs to be assessed in order to modify management. It is risky and inappropriate for a new clinician in another service to do this with lack of continuity of care, potential duplication and is likely to lead to disengagement by secondary care doctors and GPs; having initiated treatment a consultant has a duty of care to follow up until they deem them safe to discharge to another provider.

11. Needs to be a requirement of the MATT that clinical information relating to consultations, treatment and diagnostics to date are forwarded to secondary care provider at time of Choice to avoid unnecessary further consultation or investigation.

12. There is no mention of clinical governance.

13. Consideration should be given about whether the pathways should be split to spinal and peripheral. The risks around spines with the potential for missed Cauda Equina Syndrome or serious pathology are significant and other areas of the country providing a primary care based physiotherapy and interface service have experienced significant numbers of medico-legal claims for missed cauda equina.

14. We believe that it is potentially possible for the two main existing providers [OHFT & OUH] to implement this model, subject to some clarification and amendments. It would be sensible that the service is led by OHFT as the primary care provider, as is normal best practice for interface services (E.g. Southampton; Knowsley, Cambridgeshire, Brighton) and that the OUH as the Secondary care provider would provide expertise and staff on a sessional basis to support them.
Appendix L
Oxford Health Foundation Trust response to OCCG proposals

Dear Sharon,

We have now had the opportunity to review the business case document for MSK redesign and can feedback the following:

- We agree the strategic direction and will support that.
- The integrated clinical model is regarded as the best way forward to provide best outcomes for patients and will support this direction.
- Financially, we cannot form an opinion as there is insufficient information in the document. The basis appears to be the KPMG report of two years’ ago which can only set a strategic expectation but cannot form the essence of the business case. The specific costs and resources will need to be reviewed and evaluated in detail together with capacity and process assumptions considered before a business case can be established for assessment. We are willing to be involved in this.

In summary, whilst supporting the strategic direction and clinical design we are not able to agree anything at this stage other than progressing to a more detailed economic and financial evaluation of the proposed model in order to produce a full business case.

I hope this helps.

Best wishes

Mike

From: Barrington Sharon (SQE) Clinical Commissioning Oxfordshire
Sent: 13 April 2015 13:06
To: Taylor Yvonne (RNLI) Oxford Health; McInaney Mike (RNLI) Oxford Health
Cc: Blasco Ruth (RNLI) Oxford Health; Challenger Ceris (SQE) Clinical Commissioning Oxfordshire
Subject: Business case

Dear Mike and Yvonne,

Attached is the business case for the MSK service in Oxfordshire. I am sure you will appreciate we are unable to provide the full financial information due to being commercially in confidence. Thank you for giving some time to reading this. If there is any further information required that it is possible for us to provide please let me know.

Any comments should come back to me if possible.

Thanks again

Best wishes

Sharon Barrington | Programme Manager Planned Care | Oxfordshire Clinical Commissioning Group | Jubilee House | 5510 John Smith Drive | Oxford Business Park South | Oxford OX4 2LH | Tel: 01865 337006 |
email: Sharon.Barrington@oxfordshireccg.nhs.uk | NHSmail:Sharon.Barrington@nhs.net | web: www.oxfordshireccg.nhs.uk

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