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Introduction

The aim of this document is to highlight the key characteristics of best practice musculoskeletal (MSK) interface services. The document is intended for health communities (both commissioners and providers) wishing to set up an MSK interface service and for those who have already established such a service to identify further areas for development.

Through observing a number of MSK interface services in England, in particular those with pioneering models of initial patient assessment in the pathway, the NHS Institute for Innovation and Improvement (NHS Institute) has built up a picture of the ideal characteristics of such a service.

It is clear that these services, when successfully implemented, can provide considerable benefit to all MSK patients and this document provides a resource for local implementation. The ultimate aim is to reduce variation in practice and provide effective and sustainable care for patients with MSK conditions.
Musculoskeletal Interface Services: The National Picture

Musculoskeletal conditions frequently have an adverse influence on health and quality of life for many individuals and can limit daily activities.\(^1\) Recent statistics show that they are the most commonly reported type of work-related illness and take up more than 30 per cent of all GP consultations.\(^2\) They also result in the loss of an estimated 10.7 million working days in England.

**Type of MSK conditions**

- 43% Back Conditions
- 37% Upper Limbs or Neck
- 20% Mainly affecting Lower Limbs

MSK disorders are therefore extremely common and it is now recognised in the NHS that there are shortcomings in their management. Traditionally access to good care in the community has been limited and access to secondary care restricted by long waiting times. These issues are highlighted by the Department of Health Musculoskeletal Services (MSK) Framework document.\(^3\)

There is much work-in-progress redesigning services for patients with the aim of improving access to MSK services in the community and improving outcomes. This work is driven centrally by the MSK framework, the Clinical Assessment and Treatment Service Checklist,\(^4\) the 18 weeks initiative in England,\(^5\) and the Care Closer to Home policy.\(^6\)

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\(^1\) Self-reported work-related illness, Health and Safety Executive (2006-07), http://www.hse.gov.uk/statistics/causdis/musculoskeletal/index.htm

\(^2\) European Bone and Joint Health Strategies Project (2005), European action towards better musculoskeletal health: A public health strategy to reduce the burden of musculoskeletal conditions. The Bone and Joint Decade, Lund Sweden.

\(^3\) The Musculoskeletal Services Framework, Department of Health, July 2006


\(^5\) www.18weeks.nhs.uk

\(^6\) Our Health, Our Care, Our Say: a new direction for community services, Department of Health, January 2006
Redesigning Models of Care for MSK patients

Service redesign aims to make pathways centred around the patient, so that healthcare is readily available and convenient for patients, offering a full range of high quality services and advice. In this context, multidisciplinary interface services are being developed to provide community-based access to specialist MSK services.

These new models mean that patients can often avoid secondary care waits by being managed in the community and at the same time benefiting from a full range of physiological and psychological support. New staff roles are also being developed, such as Extended Scope Physiotherapists (ESPs), who are playing an increasingly central role in patient assessment and management.

The terminology for such interface services varies: names such as CATS (Clinical Assessment and Treatment Services) are variably applied. The lack of a universal label reflects their early evolutionary stage and differing historical backgrounds.

There are still many areas where patient care has not greatly improved, despite reduced secondary care waits. Patients with MSK conditions are still following variable pathways with inconsistent quality, cost effectiveness and outcomes. For example, patients with low back pain in one location can still pass via their GP to secondary care referral, be seen in A&E, present via community physiotherapy services or via a CATS to receive definitive treatment. They may also be managed by different clinicians such as orthopaedic surgeons or rheumatologists, with variable input from other groups such as pain control specialists and psychologists. Interface service structures and degree of funding also vary greatly between PCT boundaries. The sustainability and effectiveness of some services are unclear.
The approach

The NHS Institute is committed to co-producing products with frontline NHS staff and organisations. We invite clinicians, managers and patients from inside the NHS to work with us as part of our project team to ensure that the intended users are able to influence product design as much as possible.

In 2007/08 the NHS Institute initially began a project looking at best practice pathways for patients with low back pain requiring Magnetic Resonance Imaging (MRI). Low back pain was chosen as a highly prevalent clinical condition, but using a costly diagnostic resource with traditionally very long waits. During the course of this project we visited a number of organisations specifically to look at the MRI and low back pain pathway. We selected eight MRI units and five MSK interface services all from a broad performance range.

Visits to the sites were conducted over one day. Our activities included a mix of pathway observation, speaking to patients about their experiences and semi-structured interviews with a range of professions involved in the pathway.

Following the visits, we consolidated and validated the knowledge gathered. Working with frontline staff and other key stakeholders (including professional bodies and voluntary organisations) at a co-production event, the key success factors in developing and implementing an MSK interface service were discussed and assessed.

The findings have been developed into two documents:

- **Focus On: Magnetic Resonance Imaging and Low Back Pain**, which focuses more on the MRI aspects of the pathway and to imaging as a whole.

- **Focus On: Musculoskeletal Interface Services** (this document) which shares key success factors for the development and implementation of a community-based assessment service in MSK. The improvements in MSK interface services detailed in this document have the potential to allow services to be redesigned to provide more care in the community and free up significant capacity in secondary care.

*To order copies please see the back cover for further information.*
The key characteristics of MSK Interface Services providing high quality care and value for money

There is no single way to set up MSK interface services – this will depend on local circumstances – but there are several key success factors in developing and implementing such a service.

The following characteristics have been found to be the key features of successful services drawn from our observations and experiences of established services. These are followed by case studies which highlight specific elements of successful services. The key characteristics are divided into 3 key areas: structure, philosophy and functions.

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Key characteristic 1: Location and Infrastructure

The location of interface services will vary between community / primary care and secondary care, depending on local circumstances. The precise location is less important than the staffing and other structures within the service. However it should be at a site which is conveniently accessible for patients from the community with good transport links and parking facilities. Placing the service away from secondary care encourages providers and users to think differently compared to traditional models of care and therefore promotes opportunities for new ways of working. The document Delivering Care Closer to Home: meeting the challenge\(^7\) describes the facilities needed to shift care to the community.

On-site facilities should include a reception area with adequate rooms for consultation, examination, and initial treatment and additional space for multidisciplinary team meetings/presentations, and administration and management support staff.

There should also be good IT facilities to allow:
- Choose and Book referrals
- Ordering, booking and reviewing results of diagnostic tests
- Review of imaging on PACS
- Maintenance of electronic patient records.

The service should include the following staff:

- **Clinical Lead**

  This is a crucial role and requires a clinician with enthusiasm and drive to achieve the following:
  - Lead on pathway design, clinical governance, staff training, competence and mentoring
  - Maintain good communication between the various stakeholders in primary and secondary care, particularly general practitioners and commissioners.

Ideally the clinical lead should be based within the interface service rather than secondary care.

The clinical lead should have a primary clinical interest in MSK conditions (e.g. orthopaedic surgeon, rheumatologist or general practitioner) with good management skills and experience.
The clinical lead at Bolton PCT was instrumental in developing the service on a number of levels:

- Opening channels and maintaining regular meetings with secondary care providers
- Negotiating pathways
- Resolving issues as and when they arise.

One area developed by the clinical lead was a spreadsheet to capture CATS activity so that analysis of day-to-day processes could be monitored and variations on demand and capacity issues addressed in a timely manner. At a glance the team can see information such as how many referrals have been received and how long patients are waiting to be seen. This gives the team ownership of the workload so that they can contribute to flexing activity to absorb increased demand as referral rates rise so that waiting times remain consistently low.

There are multiple issues in relation to the development of pathways to secondary care with appropriate investigations and health screening prior to referral. These communication channels are essential to identify problems in the processes at an early stage.

Patients not only benefit from a well-run service, but nerve conduction studies are now carried out on-site in twice weekly sessions alongside specific clinics developed to enable a one-stop-shop approach. This approach has been essential for the service to help achieve a 18 weeks pathway and enables the team to be informed of current activity.

**Consultants**

Specialist consultant input is vital to the interface service multidisciplinary team and should include the following groups:

- Orthopaedic surgeon
- Rheumatologist
- Pain management consultant (usually an anaesthetist)
- Neurologist
- Radiologist and
- Neurosurgeon.

Consultants should take part in regular interface service multidisciplinary team meetings and staff education and development as well as playing a key role in pathway design in conjunction with all team members.

Ideally consultants should have some or all clinical sessions based in the interface service if it is community based. However the location of consultants is not vital - the primary aim is to have rapid access to consultation and opinion.
Extended Scope Practitioners (ESPs)

Primary clinical assessment by ESPs is a frequent model that is well accepted by patients and allows time for:

- Full history and clinical examination
- Ordering and interpretation of investigations
- Communicating investigation results to patients
- Giving self care advice
- Providing physiotherapy advice
- Administering other therapies such as joint injections and more recently prescribing and direct listing for surgery.

Other skills should include:

- Clinical reasoning; which is endorsed by competency acquisition, Continuing Professional Development and regular appraisal
- Interpreting all investigations requested with access to specialists (such as radiologists) for clarifying results where needed
- Understanding the best onward referral for each patient (e.g. physiotherapy, psychosocial pain management, interventional pain services, rheumatology, orthopaedics, neurology, neurosurgery)
- Ensuring re-referrals are kept to a minimum by ensuring ‘right first time’ assessment and treatment.

Other MSK practitioners

These will include: podiatrists, specialist nurses, GPs with a specialist interest, occupational therapists, general physiotherapists, and psychologists. These services will often be shared with secondary care and ideally there should be a unified workforce planning and management structure across the sector.
Case study
Multidisciplinary approach to providing MSK services
Orthopaedic Choice – Hampshire Primary Care Trust

Orthopaedic Choice in Hampshire is a good example of a service which provides a wide variety of expertise to patients in a community setting, whilst maintaining strong links with secondary care. The service consists of 26 orthopaedic consultants from the three local acute trusts, two pain management consultants, and a number of ESPs.

Prior to the creation of Orthopaedic Choice there were long waits for specialist opinion in secondary care, with only this single referral route for MSK patients. In order to provide rapid access to appropriate expertise, a multi-professional team was established in a community setting to provide an alternative referral route available for General Practitioners. The service now has clear clinical governance and staff development structures, direct access to diagnostics, and is staffed by secondary care clinicians including orthopaedic surgeons, radiologists, and pain management consultants.

Orthopaedic Choice offers short patient waits, a 30 minute consultation with an ESP, and ready access to an on-site specialist for opinion when required. The consultant presence also facilitates ongoing staff development and training. All patients who require surgical intervention are assessed for fitness for surgery prior to onward referral to a choice of providers.

The new service has led to a number of benefits to patients and staff:

- Increased patient and staff satisfaction
- Reduced waiting times with early access to diagnostics
- Patients receive appropriate treatment closer to their homes
- Direct listing for secondary care referral
- Reduced referrals to acute secondary care
- Role development supported by senior clinicians.

In spite of increasing demand for the service, financial balance has been met, and investment made into new physiotherapy and podiatry services to help maintain short referral to treatment times. The service has robust data demonstrated by Practice Based Commissioning which showed reduced surgical procedures per 100 population and reduced new to follow up ratios in outpatients.
**Business manager**

This role provides important leadership in partnership with the Clinical Lead. The success of the service is dependent on the initial business case and project plan and the management expertise to sustain its delivery and expansion. The complexity of financial flows requires a strong business leader to drive the service forward. Negotiating and securing new types of working contracts is a key influential element.

Roles will include:

- Managing contracts and finances
- Staffing
- Business cases
- Communications and marketing
- Collection and management of data on referral and outcomes.

**Administration staff**

The most effective services have administration support within the same facility as the service and not as a remote support. Staff should provide patient reception, booking, IT administration and the full range of administration services necessary to support the service.
Key characteristic 3: Strong Clinical Network

Multidisciplinary team members should work closely together as a strong clinical network. The network should have a robust system of training, competence assessment, education and role development. Team meetings and case discussions should be held regularly at least once a week.

Case study
Introducing regular Multidisciplinary Team meetings
Orthopaedic CATS – Bolton Primary Care Trust

Education Continuing Professional Development sessions run for two hours every Wednesday afternoon. They are tailored to developing the needs of the service with topics generated by the team. This includes same sessions and significant event audit.

For instance a recent event highlighted that a GP organised appropriate blood tests after referral to the service. This meant when the patient attended several days later the clinician was unaware that the tests had been performed, or of the abnormal results.

In response, access to pathology results in clinic for all staff was reorganised and the importance of its use emphasised. For the patient this means any abnormal findings are found without delay and can be acted on quickly.
Care is now delivered in a variety of settings such as acute hospitals, community hospitals and the home. The tariff should not be an obstacle to this diversity of provision.

Outpatient tariffs include the cost of diagnostic imaging that has been commissioned as a result of an outpatient attendance. Given the 18 weeks target, it is increasingly important to ensure that there are incentives for PCTs to commission imaging scans via direct access prior to secondary referral. This helps to reduce the time people have to wait for tests and reduce the number of unnecessary referrals to secondary care outpatient clinics. Commissioners should avoid any perverse incentive to refer all patients to outpatients on financial grounds (e.g. if the outpatient tariff is lower than the cost of commissioning an imaging scan via direct access).

Commissioners and providers were expected to reach agreement on their local approach to unbundling for their 2008/09 contracts. Providers and commissioners need to engage to adjust tariffs, particularly where commissioners seek to move part of the care pathway to a community-based interface service.

In particular, unbundling diagnostics may be a critical component of the local strategy for achieving the 18 weeks target. Wherever there is a ‘bottleneck’ caused by shortage of diagnostic capacity, commissioners and providers must reach agreement on unbundled diagnostic prices (including corresponding adjustments to the outpatient tariff). It is for local judgement to decide where diagnostics are implicated in long waits.

Whatever the local solution, refusal to agree to a local unbundling approach by either commissioner or provider must not be an obstacle to service redesign.
It is important that the service collects data to monitor its performance and outcomes against local and national standards.

The following is a suggested list of data that an interface service should monitor continuously:

- 18 weeks referral to treatment data
- Appropriateness of referrals into service
- Did not attend (DNA) rates
- Number of new attendances and follow-ups
- Treatments performed in the service and outcomes
- Appropriateness of referrals to diagnostic tests such as MRI
- Onward referral rates to secondary care
- Surgical intervention rates within secondary care
- Capacity and demand monitoring
- Turnaround time for diagnostics.

There should be systems in place to monitor 18 week clock starts when patients are referred to the interface service and clock pauses.
Defining and agreeing the aims of the interface service from the outset across the health community is crucial. It is important that the interface service is not just seen as a referral triage system to reduce the demand on secondary care. A key aim should be to appropriately provide a single point of access for patients presenting with MSK conditions with a unified policy of care. Documenting the aims of your service is important so that all staff are aware, understand and are committed to the philosophy and aims of the MSK interface service.

Case study
Aims of the Service: Musculoskeletal Interface Service (MSIS) Somerset and Taunton Primary Care Trust

Aims of the Service

The Musculoskeletal Interface Service (MSIS) is a collaborative service with primary and secondary care working together to improve the quality of the service provided to patients. It was set up in February 2000 with the aims of:

- Providing patients with early access to a specialist opinion in a community location
- Providing early access to investigations
- Ensuring those patients referred to an Orthopaedic Consultant have had the appropriate treatment and investigations prior to referral
- Ensuring that only those patients who require a surgical opinion are referred to the Orthopaedic Surgeons
- Providing all patients with information and advice on their condition aiming to improve their self management strategies and quality of life whether surgical treatment is indicated or not.

Philosophy of the Service

The clinicians within the MSIS practice the bio-psychosocial model of care. In this model a pathological cause for symptoms is sought; but if it cannot be defined and sinister pathology is excluded or despite identifying the pathology there is no surgical solution, the patients are given an explanation about their symptoms and given advice and information about all conservative and self management strategies.
Unified policies of care ensures appropriate referrals both into the service and beyond into secondary care. There should be clear locally agreed referral pathways based on national guidance. It requires excellent communication and feedback to referrers. Ideally agreed pathways should be linked to commissioning contracts.

Below are some useful links.


European guidelines for management of back pain in primary care

http://www.backpaineurope.org/

Case study
Developing a Multidisciplinary Back Pain Service
Birmingham East and North Primary Care Trust

The PCT had no multidisciplinary assessment in primary care. Patients requiring pain management had to travel to a variety of hospitals across Birmingham.

Patients were often referred to the wrong place, had been seen previously and faced long waits of up to two years for appropriate treatment.

The new service has streamlined processes leading to a seamless pathway between primary and secondary care ensuring that patients receive early local access to a ‘one stop shop’. This provides appropriate assessment, advice, investigation and treatment from a range of professionals (including doctors, physiotherapists and psychologists) able to address all aspects of bio-psychosocial need and identify and treat barriers to recovery. Waits have now reduced to 3-5 weeks for a first appointment.

Patients may be referred from the assessment clinic to primary care services (including physiotherapy, podiatry, expert patient programme or exercise on prescription), for investigation (MRI, X-ray, blood tests) or may be listed for an appropriate intervention (e.g. facet joint injection) without requiring a further hospital appointment.

The multidisciplinary team also provides ongoing education and training to GPs and other primary care health professionals.

The service provides ‘Active for Life’ advice and exercise courses for patients with chronic musculoskeletal pain at a number of locations. A video, funded by the Strategic Health Authority, providing education on exercise and activity on ‘Active for Life’ has also been produced which is available to GP practices and patients.
Key characteristic 8: Patient Centred Service

The service should be centred around the patient by:

- Providing all patients with information and advice on their condition with the aim of encouraging self-management and improving quality of life
- Providing a wide base of clinical support e.g. psychological assessment, occupational therapists and patient self-care literature
- Communicating clearly with patients e.g. direct booking of appointments and regular patient surveys
- Aiming for a minimal number of patient visits to complete the pathway
- Providing adequate time to assess patients in a comfortable environment, respecting patients’ needs and privacy.
Creating a single point of access for patients is important so that:

- The maximum number of patients benefit from the improved service
- Cost effectiveness and short waits can be achieved
- The service can be more easily managed
- Outcomes and effectiveness can be measured accurately
- Guidelines can be agreed and followed effectively ensuring appropriate use of diagnostic and support services
- Secondary care specialist staff can be used more effectively
- Patients know what to expect.

The single point of access can prove a challenge and requires excellent communication across the healthcare community, particularly with GP’s (see Key Characteristic 11), and also a funding stream that encourages use of the interface service (see Key Characteristic 4).

**Case study**

**Creating a single point of access**

**Back Pain Service Organisation – Somerset PCT and Musgrove Park Hospital**

The PCT streamlined the MSK pathway by creating a single point of access which offered a range of improvements for patients and the service.

The benefits include:

- Fewer healthcare interventions
- More cost effectiveness in comparison to usual GP referral systems
- Lower prescribing
- Less referrals onto secondary care
- Lower investigation rates in the self referral system

As a result patients feel more involved in the process of their care and therefore are more compliant with their treatment which has resulted in lower did not attend (DNA) rates.
Key characteristic 10: Rapid Patient Access

In view of the 18 week pathway, four to six weeks is attributed to referral to first outpatient appointment and with a further four weeks allocated to diagnostics. Therefore ideally patients should wait less than four weeks from decision to treat to receiving treatment. With the continued reduction in waiting times, many acute trusts are being challenged to deliver treatment within 12 weeks. This requires a new approach to accessing services. Self-referral is a new model of care which is being applied in Scotland who describe it as ‘the ability of a patient to access a healthcare practitioner without having to see or be referred by anyone else first. This can involve the use of electronic means (i.e. via email or the web, telephone access or face to face) www.selfreferralphysioinfo.com

The White Paper ‘Our Health, Our Care, Our Say’ (2006) made a commitment that ‘in order to provide better access to a wider range of services, we will pilot and evaluate self referral to physiotherapy. We will also consider the potential benefits of offering self-referral for additional direct access for other therapy services.’ The Department of Health and Chartered Society of Physiotherapy piloted self referral in MSK physiotherapy with six pilot sites. Benefits from the pilots included:

Patient benefits

- High levels of service-user satisfaction and confidence
- A more responsive and attractive service to patients with acute conditions, affording them wider access
- Empowering of patients to self-care / self-manage to meet their needs
- Lower levels of work absence.

Service benefits

- 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.

A template referral form has been produced by the Department of Health in the ‘Self-referral pilots to physiotherapy information pack’. Visit http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081067
Case study
Introducing self-referrals
Collaborative Back Pain Service Organisation – Somerset PCT and Musgrove Park Hospital Foundation Trust

The PCT created a direct access pathway to a MSK specialist service. This empowered patients to take control of their own condition, encouraging a habit of self-care.

Initially a self-referral service was set up from two GP practices, where patients could choose to refer themselves directly to a physiotherapy department. Physiotherapists underwent extra training from extended scope physiotherapists in order to work as first contact practitioners.

The new pathway enabled physiotherapists to order x-rays and administer cortico-steroid injections where appropriate. Links were improved with the existing musculoskeletal interface service so that physiotherapists could refer patients directly to that service where further investigations and expertise could be provided.

Patients were given the chance to choose who they saw, particularly in accessing a ‘specialist musculoskeletal physiotherapy service’ rather than a general practitioner who may not specialise in MSK medicine. For GPs it meant less administration time, as letters to physiotherapists were not required.
Key characteristic 11: Excellent Communication with GPs

Communicating well and effectively with GP referrers is vital for the MSK service and will:
- Ensure appropriate referrals
- Maintain short waits
- Reduce variation in patient pathways
- Maximise the number of patients referred via the common pathway

Case study
Involving GPs in a Collaborative Back Pain Service
Somerset PCT

The Musculoskeletal Interface Service in the Somerset Coast area has been in service since 2000. It has a national profile as an example of best practice and has been involved with the Department of Health outlining how this type of service can be delivered.

Despite the national recognition of the service, the profile among local users was unknown. Therefore a questionnaire was designed to collect the thoughts of the GPs who refer patients to the service.

From the responses the service learnt that:
- 56% of GPs felt their patients were seen quickly enough following referral (44% felt there was still some delay)
- 50% felt a waiting time of 4 weeks or less was acceptable, 33% felt a wait of between 4-6 weeks was acceptable with the remainder happy with a wait of over 6 weeks
- 87% were satisfied or very satisfied with the outcome of the patient referral
- 74% felt the musculoskeletal interface service has significantly or moderately improved patient care for this group of patients
- 91% felt that the interface service is a valuable addition to primary care services, with 100% supporting the continuation of the musculoskeletal service as a core service in the PCT
- 57% thought that this model could be adapted and used to develop other primary care interface services especially ENT, Gynecology and respiratory medicine.

Comments from the questionnaire included:

*I have had some very good feedback from patients. It allows us to reassure patients and we know if they are referred, the advice will be the same so we do not get undermined.*
Key characteristic 12: Direct Access to Diagnostics

There should be direct access to diagnostic tests including standard blood tests, plain x-rays, and MRI. Diagnostic services should be geographically convenient with short waits. In addition, good IT links are required to allow rapid ordering, booking, reviewing results, and access to images via Picture Archiving and Communications Systems (PACS).

Indications for diagnostics should be agreed and audited. Full relevant clinical information should be provided with diagnostic requests. The person making the request should be fully able to interpret the diagnostic report and convey it implications to the patient in an informed and constructive way. Ideally a radiologist should be included in the multidisciplinary team to discuss cases and provide specialist opinions.
The agreed pathways should enable appropriate patient triage by clinicians and timely onward referral to secondary care when appropriate e.g. fit for surgery assessment. In particular there should be a rapid referral route straight to secondary care for patients with “red flag” symptoms or signs, for example neurological signs in patients with low back pain.

Case study
MUST Service (Musculoskeletal Triage Service)
Kingston Hospital NHS Trust

The PCT employed four ESPs to triage, assess including organise relevant diagnostic tests and arrange onward management for a variety of orthopaedic conditions. The aim was to improve the patient journey and reduce waiting times.

Allowing ESPs to directly list patients for surgery and see post operative follow ups, along with additional day surgery reduced waiting times for carpal tunnel decompression from up to 76 weeks to just four weeks.

The service now meets the 18 weeks target. A range of other benefits have been identified:

- Shorter waits to see ESPs compared to consultants
- Flexibility of staff mix within the service
- Fewer follow-ups
- Patient information sheets are provided at the initial appointment including briefing for hand surgery.

To ensure that the change in service delivery is achieving the required aims, services should understand the new to follow-up ratio within the new service and compare this to the original pathway. Services should also consider the conversion rate of referrals to secondary care and surgical treatment in the case of orthopaedics.
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- British Orthopaedic Association
- British Osteopathic Society
- British Pain Society
- British Society for Rheumatology
- Chartered Society of Physiotherapists
- Department of Health (Chief Professions Officers)
- MRI Fastrack Diagnostic Scheme, Department of Health
- National Imaging Board
- National Radiology Service Improvement Programme
- Primary Care Rheumatology Society
- Royal College of Radiologists
- Society and College of Radiographers.
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