Northamptonshire
Health and Care Partnership

# Musculoskeletal Services For Northamptonshire –

# The MSK Work-Stream: Referral Management

June 2019

# Introduction

- The pilot approach to managing musculoskeletal referrals (T&O; Pain Management; Rheumatology) has been delivered by Circle, who were appointed to run a paper-based “Referral Management Service” (RMS)
- Some GPs have utilised RMS; Some GPs have not used.
- There have been increased waits for physiotherapy.
- Clinicians have expressed frustration at the lack of clarity in the system.
- The system needs to come together to decide what to do for musculoskeletal referrals to deliver the best outcomes for patients
- This presentation engages stakeholders in deciding what referral management will look like in the future
- We are talking to Provider Clinicians (Inc. the MSK Core Group); GPs (Inc. Locality Boards); CCGs (Joint Executive Management Team); Patients – Healthwatch and NHCP Clinical Leaders

# Background – MSK Work-Stream: Remit and Parameters

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- Following a workshop in March, the MSK work-stream was set up and tasked with implementing the Musculoskeletal Care model devised by the MSK Core Group in 2016.
- The model is still supported by the MSK Core Group, noting that there are changes that will affect the model e.g.:
  - Introduction of First Contact Physiotherapists
  - Development of Primary Care Networks
- Emphasis on
  - Building on existing work
  - Consistency across the county
  - Engaging with all stakeholders
  - Developing a network approach with all elements of the system working together.
  - Making the most of scarce staffing resources

# Proposed Model of MSK Care

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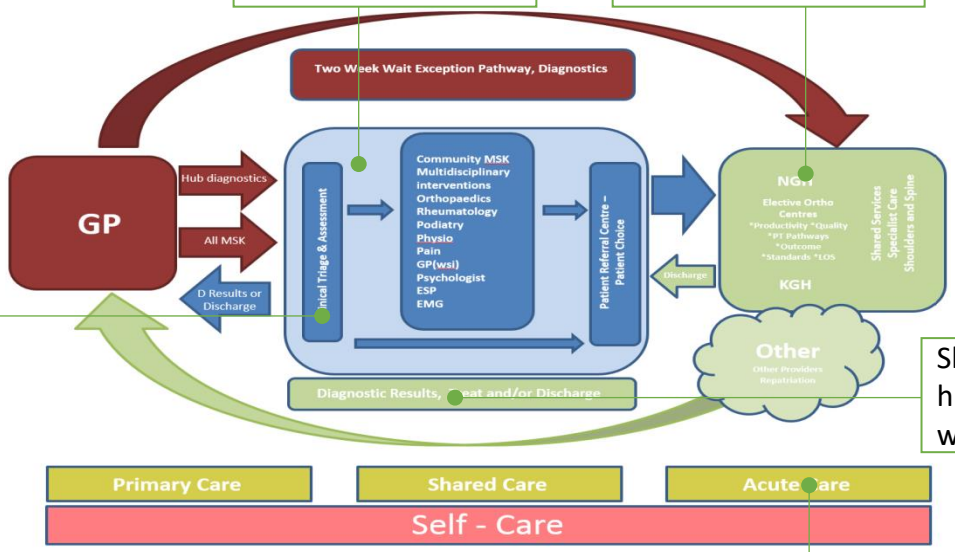
**Outpatient clinics**:
- KGH
- NGH
- Nene Park
- Isebrook
- Corby
- Danetre

Orthopaedic hub clinics at NGH and KGH

Surgeries/procedures performed at both NGH and KGH

**Trust-level enablers**:
- Shared IT system across Trusts
- Improved clinical skill mix and on-site rotas
- Reduced cost of prosthetics and consumables




Orthopaedics MDT to triage patients

Shared diagnostic hub from radiology work

**Orthopaedics Multi-Disciplinary Team (MDT)**:
- Consultant
- Extended Scope Physiotherapist
- Specialist Nurse
- GPwSI
- Podiatry

Post-op self-care supported by community-based health services

**Comments – This model needs some re-design as it does not reflect current primary care model of care. e.g. First Contact Practitioners (FCP). The model was also designed prior to Circle RMS and when T&O, Rheumatology and pain were separate work-streams. An equitable countywide hand therapy service needs to be included in the design. Similarly, MSK podiatry also needs to be included in the re design and commissioning. With FCP being part of the elective front door, most triage/ diagnostics will be concluded prior to referral secondary care. There is also a need to incorporate a wider therapy service model to OT, community therapy services etc. so that we have a clear referral pathway.**

# Possible Change to the Proposed Model of MSK Care

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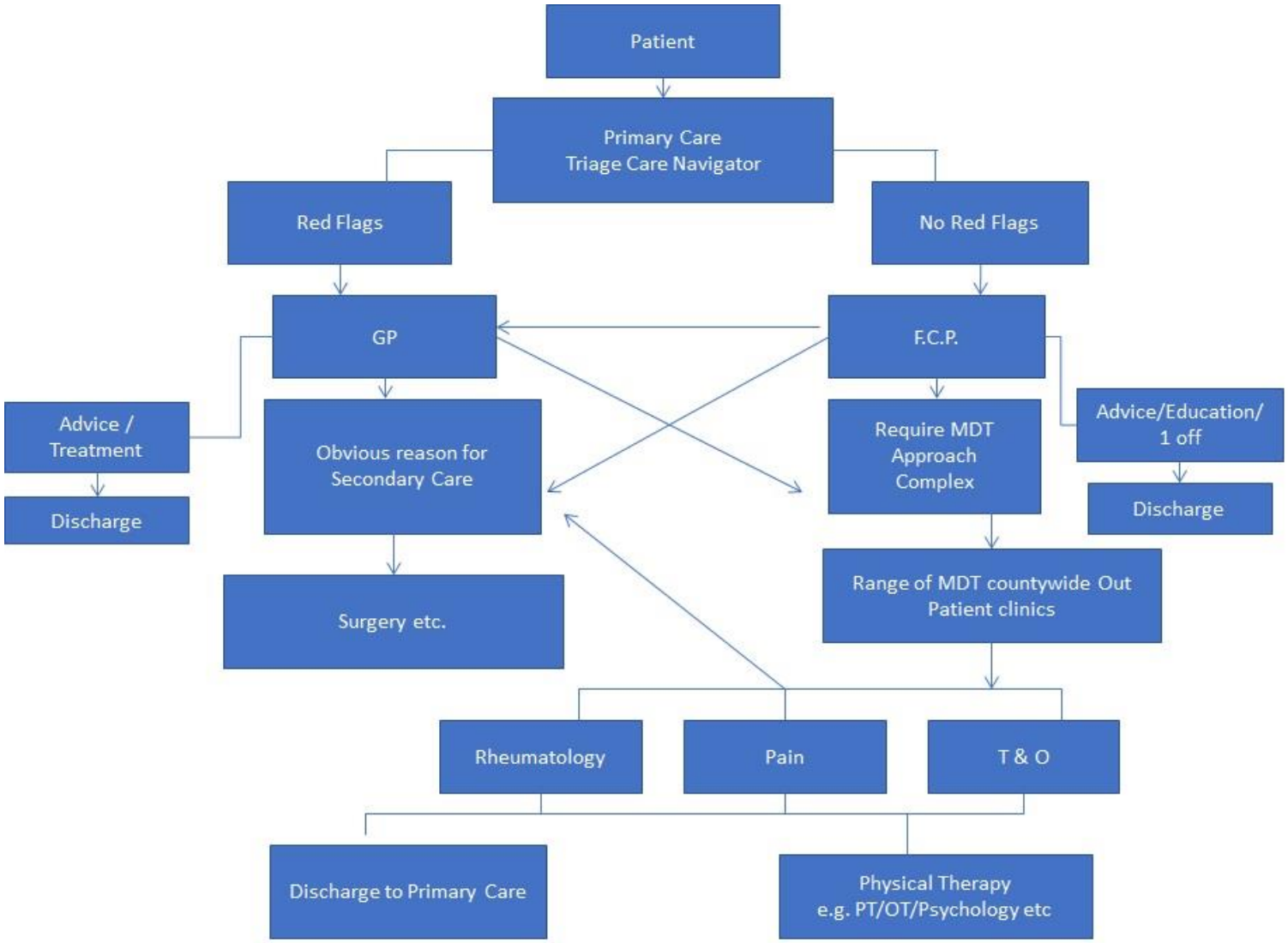

# Delivering a New Model of MSK Care – First projects in 2019 & 2020

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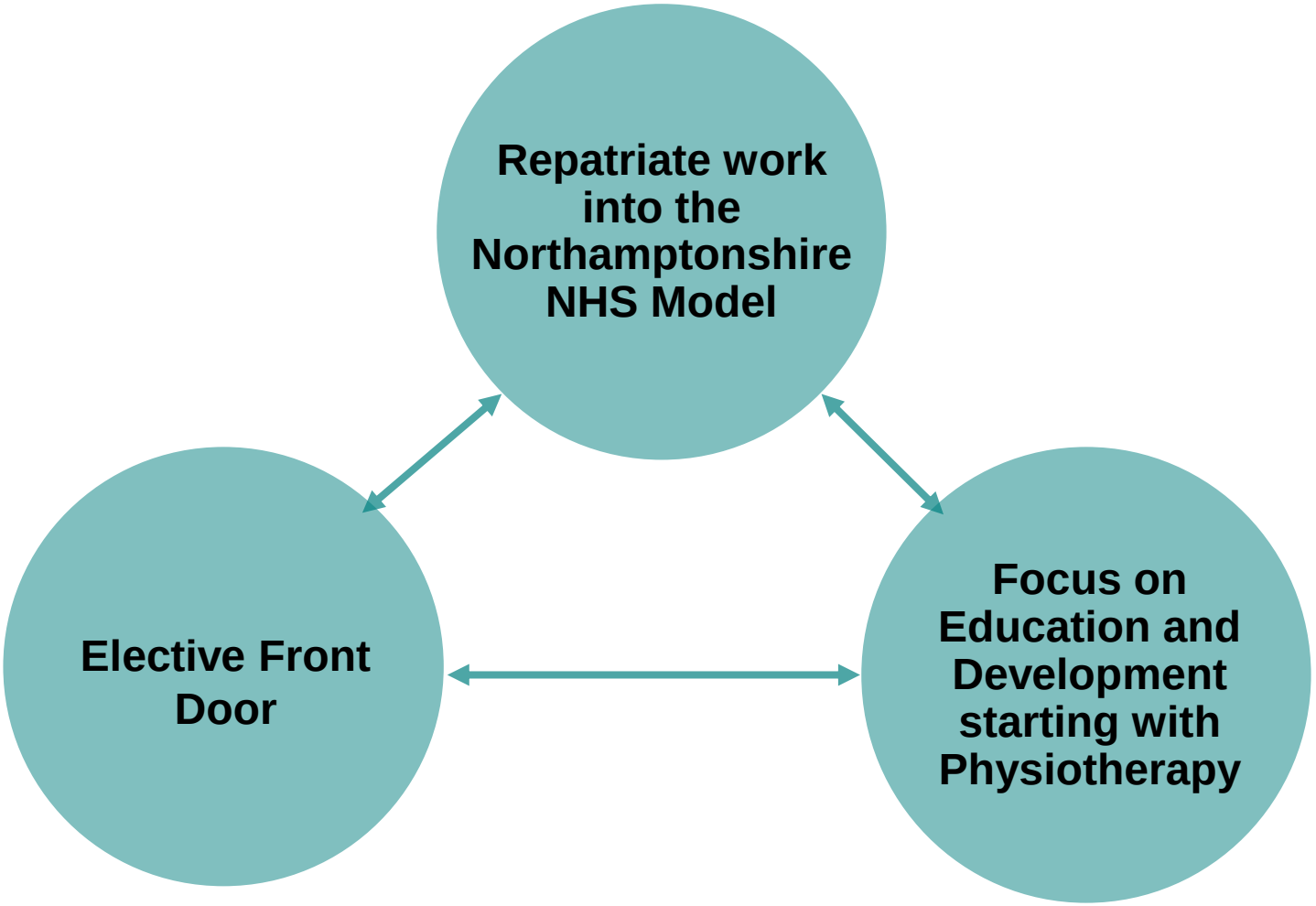
It must be noted this whole pathway redesign for Rheumatology, T&O and Chronic Pain Management to enable the CCG to commission a whole pathway of care. The three elements below are in the early parts of the whole process.



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# First Contact Physiotherapists (FCPs)

- The main reason for, and benefit of, FCPs is that it supports GPs and creates GP capacity
- There are several benefits to be maximised from an FCP service:
  - It integrates with primary care and filters out patients who don't need on-going care **[reduces referral to hub and hospital]**
  - It integrates with "MSK hub" to deliver NHFT services which might be needed by patient (OT/Podiatry/Hand Therapy/Psychology) **[reduces referrals to hospital]**
  - It selects which patients may benefit from "outreach" specialist input which could be delivered as part of a complex patients MDT assessment **[pre-selects pathways required for maximum patient benefit if an MDT is available, decide if community /hospital care]**
  - It pre-selects diagnostic procedures and investigations.
  - It selects which patients need to progress further to Specialist areas. It is possible some of this may be accessed in peripheral clinics or might require sending on to acute trust. **[Makes more effective use of specialised care]**
- Possible risks from FCPs (e.g. unnecessary delays to patient care/ duplication of work) can be managed by clear referral pathways/ protocols / safety netting. Appropriate mentorship is essential.
- One point for discussion is that the " MSK hub" may be seen as an outreach element of the whole MSK service (however we envision this working). The FCP is in this setting can be seen as an outreach practitioner of the MSK service and in that way we can ensure the correct governance of the process is in place to ensure that the whole pathway GP/FCP, Community MSK/Hub, Hospital MSK are fully integrated.

# Referral Management – Current Situation

- The MSK Model of Care aims to:
  - Offer an effective single elective MSK referral front door; and
  - Standardise/ optimise service usage for all MSK Elective referrals.
- The current RMS pilot:
  - Has more than one entry point as it allows for unfettered direct referral;
  - Provider has been asked to continue until September 2019.
- The development of First Contact Practitioners should help support the direction of referred work more effectively
- There is a need to demonstrate ‘genuine’ patient choice, standardise pathway management, and support collaborative working between partners to manage referrals into secondary care.

# Possible Options for Referrals in Developing the Model of Care

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A task group of consultants, therapists, nurses, GPs, commissioners and managers, from across specialties and organisations met to consider the following options:

1. Continue with the current RMS model.
2. Do Nothing
3. Ask another provider to carry out the triage work virtually, building off existing referral management approaches
4. Peer to Peer MSK review at GP practice/Primary Care Network (PCN) level
5. Accelerate the First Contact Physiotherapist (FCP) process and combining with triage.
6. Development of an Multi-disciplinary (MDT) Hub
7. Other Options?

The option to competitively tender referral management was not put forward. This reflected the discussion when CCG/Provider contracts were agreed this year where the CCGs would look to not go to the market place.

# Discounted Options

After the first part of the discussion, the task group discounted the following options:

1. Continue with current RMS model – Paper based triage was seen as a process that added little if no clinical value.

2. Do Nothing – Not acceptable as this would likely ‘swamp’ the MSK system and also lead to patients being passed between services.

3. Ask another provider to carry out the triage work virtually, building off existing referral management approaches. A separate provider fragmented care and also may prevent ‘genuine’ patient choice.

# Supported Options

After the first part of the discussion, the task group supported the following options:

4. Peer to Peer review of MSK at GP practice/PCN level.

   The principle of peer to peer review was supported but it was noted that to date this has not made significant changes to referrals and subsequent activity. It may be more effective at a PCN level.

5. Accelerate the FCP process and combining with triage.

   This is a national requirement and there is partial funding. The pilot FCP work in Northamptonshire has been successful and the work has been presented at regional workshops.

   It was fully supported to maximise this opportunity but also that the pace of delivery because of workforce development would mean that this could not be the only opportunity in the short to medium term

6. Development of an MDT Hub

   The MDT Hub concept was supported but needed further refinement.

# Further Discussion

The Task and Finish Group, after further discussion, concluded the following:

- One First Contact Physiotherapist per PCN area is the national goal for 2020-21. With variable PCN populations, more than 1 would be sought for larger PCNs. Local development of FCPs is preferred. Offering to host student physiotherapists in the community is one recruitment option but does impact upon physiotherapy time and so needs to be discussed.
- Direct referral letter to Rheumatology was supported as most work currently does not come via RMS, but requires further work. Some patients can be seen and discharged or referred on, but such referrals were appropriate to discount rheumatoid issues. Referrals with adequate information can be directly diverted to physio/ podiatry/FCP/ hand therapy from paper triage or early referral back from Rheumatology via the hub.
- It was in the patient's interest that any onward referral be direct (not back to the GP first)
- All MSK referrals that may end up with T&O first have a physiotherapy assessment at a supra-PCN level, perhaps at a hub covering 100,000 (7-8 hubs across Northamptonshire). This would improved triage and early intervention to prevent deterioration. It would also allow 'pre-habilitation' to commence for patients who faced potential (joint replacement) surgery. Patients who had come via an FCP would not have a further assessment.
- Chronic Pain Management can be seen almost as the last step in the MSK pathway (after other options had been explored). Referrals could benefit from a full MDT assessment ahead of that to ensure appropriate other steps had been followed, although some referrals could be dealt with through direct written referral. Access to AHPs including clinical psychologists to intervene early in pathway at the hub is desirable.
- The MDT hub would also be available where no appropriate course of action was apparent.
- The cost of the Hub would need to be agreed and managed.

# Proposal from the Task and Finish Group

1. The Paper-based RMS be allowed to finish. A conversation is required with the provider
2. Longer term a model develop that includes First Contact Physiotherapists, Physiotherapy clinical assessment for MSK referrals that may require T&O, and a multidisciplinary hub which would help target chronic pain work. Direct referral to Rheumatology would be allowed. All MSK referrals would come through a single portal so as to record all work, ensure the work is being managed as per pathway, and help direct where it is required. To ensure continuity, it is proposed that the gateway would be with NHFT to build on existing referral hubs and to access physiotherapy (and other therapies e.g. OT and psychology)
3. In the shorter term, the role out of FCPs will be maximised and the opportunities for peer-to per be considered to make the process transparent as possible and so be more effective.
4. The conversation now be widened across all stakeholders Consideration must also given to
   - Clear idea of service required – T&O specialty MDT (e.g. shoulder, knee, spine etc.); Chronic Pain services (e.g. Pain management programme or consultant/intervention clinic); Rheumatology specialty services (e.g. Early Arthritis Clinic, CTD clinic, Osteoporosis clinic etc.); Complex needs for which MDT input required (possibly/probably with a single MDT hub)
   - Where the referral destination is unclear MSK MDT assessment will define patient needs and which services need to be involved. This overlaps with the complex needs work and includes cases beyond what can reasonably be provided in primary care. Potential roles could include GPwSI or secondary role for FCPs working within an MSK hub with access to support from specialties as well as hub diagnostics
5. A final approach be agreed by the end of June and a work plan, and task team, be agreed to develop the finer detail of the approach and implement the model.

# Be proactive…..Get involved

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- Engage with the transformation process
- Help us redevelop the front end to the elective pathway, provide your expert view.
- Survey of views on survey monkey
- Link: https://www.surveymonkey.co.uk/r/Q6LZB8M
- Engage with everyone, share with colleagues
- If you want to know more, please contact richard.bailey1@nhs.net Musculoskeletal Programme Lead for more information