Outline Service Specification

Service Specification No.	
Service	Integrated MSK Triage Service, including Therapies, Pain, Rheumatology, Podiatry, Physiotherapy, elective in-patient Orthopaedics Service
Commissioner Lead	S Borrington, Commissioning Manager
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

MSK conditions have a significant social and economic impact and over 200 MSK conditions affect millions of people. These conditions include all forms of arthritis, back pain and osteoporosis, some of which can result in long-term functional disability. Latest estimates suggest that 30% of GP consultations are for MSK conditions. It is recognised that the ageing population will continue to further increase the demand for age related disorders.

Direct access services that include self-referral have been piloted across the UK and evidence from these have shown that patient self-referral for MSK conditions within the NHS does not increase waiting lists. Routine physiotherapy services mostly place GPs as 'gatekeepers' to physiotherapy services, however direct access initiatives with self-referral have identified real benefits for patients in terms of choice, access and patient satisfaction
Musculoskeletal disorders have a significant social and economic impact. Data from the Health and Safety Executive indicate that in 2006/07 1,144,000 people in Great Britain suffered from a musculoskeletal disorder caused or made worse by their current or past work equating to 2.7% of people who have ever worked in Great Britain. Data from the Labour Force survey over the last 5 years indicated that on average 10 million days were lost due to musculoskeletal disorders every year, second only to stress, depression and anxiety. The average annual days lost per case in 2006/7 was 16.7 days with 0.46 days lost per worker. In the UK, it is estimated that the total cost to the nation of musculoskeletal disorders is £5.7 billion, annually.

The Musculoskeletal Services Framework (MSF) is the Government's strategy for long-term conditions, which includes "Supporting people with long-term conditions: Improving care, improving lives" and the "National Service Framework for long-term conditions." The overall vision is that 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.

The Our Heath, Our Care, Our Say white paper also suggests patients should have real choice and greater access to health and social care, with services being delivered safely and effectively in the community or closer to home.

Wirral Overview
Wirral is a borough of contrast and diversity in both its physical characteristics and social demographics. There are both rural areas and townships, urban and industrialised areas in a

compact peninsula of 60 square miles. The borough has parks, countryside and over 20 miles of coastline. Wirral currently experiences a variety of challenges specific to its locality and demography, as well as future pressures which face health and social care systems nationally.

In total we look after the health needs of approximately 330,000 people within Wirral, from 52 GP practices.

Population Profile
Wirral has a relatively high older population and a relatively low proportion of people in their twenties and thirties compared to England and Wales as a whole. The older population (aged 65 years and above) are expected to increase at the fastest rate (than any other age group) over the next decade; between 2011 and 2021 it is estimated that this population group will have increased by 17.4%. The population over 85 is projected to increase from 8,460 in 2011 to 10,985 in 2021, which equates to a 29.9% increase. The biggest decrease is in the 35-59 year age group, from 108,548 in 2008 to 82,061 in 2021. Births reached a 15 year high in 2011.

The Index of Multiple Deprivation (IMD) places 30 of Wirral's LSOAs in the lowest 5% in England and 23 Lower Super Output Areas (LSOA) in the 3% most deprived nationally. The Employment domain of the IMD 2010 indicates that Wirral performs poorly on this indicator. This is an indication of the scale of the challenge faced in Wirral and the need for a focused and coordinated approach to tackling work-lessness and economic inactivity. Wirral has a predominance of 'Mosaic' groups which are at the polar extremes of the income spectrum, indicating that the differential between people on very low and very high incomes is quite pronounced in Wirral.

30,000 over 65s reported in the 2001 Census that they were living with a Limiting Long Term Illness. The most deprived areas have much higher emergency hospital admission rates than the rest of Wirral. Lifestyle behaviours such as smoking and drinking too much alcohol, as well as obesity, contribute to health inequalities, and these behaviours are all more prevalent in Wirral's most deprived areas. Birkenhead, Tranmere, Bidston, Seacombe and Rock Ferry have between 50% and 70% of older people living in deprivation.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

	Activity	Measure
IMPACT	Number of patients self-managing their condition. Number of patients satisfied with their treatment and support.	Patient Questionnaire 9 months after discharge. Quality of Life Questionnaire.

	Reduction in GP appointments for same problems / symptoms. Avoidable referrals to Orthopaedics are reduced. Patients waiting times meet or exceed local and national targets Average health gain for patients receiving Hip and Knee replacements in in line or better than the national average Hip and knee revisions are in line or better than NICE guidelines.	Patient and Friends & Family questionnaire at periodic points and discharge. Reduction in GP presentation at practice. Reduction in referrals where patients are discharged after first appointment. Increase in conversion rates to surgery. 18 week referral to treatment target EQ-5D index score / Oxford Hip & Knee score National Joint Registry
OUTCOME	Patients are pro-actively involved in decisions about their care. Patients are satisfied with the bundle of treatment and care provided. Patients receive the most appropriate treatment and care to meet their needs. Patients are directed for orthopaedic surgery once all non-surgical options have been discounted Patients are supported and enabled to self-care through appropriate information and advice	Patient questionnaire. Patient questionnaire. Repeat symptoms questionnaire. Intervention statistics. Surgical conversion rates Patient Questionnaire Referral, intervention and discharge statistics.
OUTPUTS	Number of patients referring into, treated and discharged by condition: - MSK conditions - Podiatry - Rheumatology - Pain Management - Orthopaedic surgery - Physiotherapy	Referral, intervention and discharge statistics. Referral and surgery statistics

	Number of patients discharged to self-care Number of patients referred for Orthopaedic surgery successfully converted to surgery	
INTERVENTION	Patient Management plans will be developed for each patient to identify the best treatment and care package.	Percentage of patient plans in place, with individual QOL and symptoms baselines.
INPUTS	Patients requiring MSK treatment, or associated services provided via the triage service.	No of patients referred.

3. Scope

3.1 Aims and objectives of service

A review of MSK referral and provision has been undertaken and the CCG are wishing to implement a multi-disciplinary, consultant led Integrated MSK triage service. This will include physiotherapy, pain, rheumatology, podiatry and orthopaedic management and surgical services that will streamline the referral of patients, directing them quickly to the most appropriate care.

A number of service models have been considered for the Clinical Assessment and Treatment of MSK conditions. This specification sets out the parameters of the required model including patient self-referral.

The focus of the service will be in providing patients with timely assessment and management of MSK conditions, including community based access to key services such as physiotherapy, pain, rheumatology and podiatry, along with elective orthopaedic surgery, prompt referral to wider services e.g. lifestyle, delivery of advice, therapeutic management, education and support, enabling the individual to achieve and maintain independence and well-being.

The service provider will be responsible for the the full range of MSK services, this may be through direct provision or sub-contractual arrangements. The key service areas are below. This is described in more detail in the section – Treatment Services

- Physiotherapy
- Pain Management
- Rheumatology
- Podiatry
- Work up for surgery
- Elective Orthopaedic surgery
- On-site high dependency and critical care
- Management of diagnostic referrals
- Provision of Nerve Conduction Studies
- Provision of low level orthotic devices such as maternity belts, wrist splints, sacroiliac belts, heel cups, epicondylitis braces etc.

The provider will be responsible for all provision under these areas; this includes non-MSK related provision physiotherapy and podiatry.

Aims:

Service Aims:

- Improve patient access to MSK services through the triage process.
- Reduce the number of GP consultations for MSK conditions.

- Improve communication with GPs about the progress and outcomes for their patients.
- Reduce unnecessary repetition of unsuccessful treatments or approaches and potential unnecessary interventions
- Reduce avoidable referrals and admissions.
- To manage patient flows through primary and secondary care, ensuring appropriate and timely onward referral to specialist services.
- To improve the patient care pathway for MSK conditions to deliver tangible benefits for patients.
- Achieve a maximum referral to treatment time of 18 weeks for all services with the scope of the 18 week RTT target.
- To ensure appropriate onward referral to other services e.g. Occupational Therapy, Dietetics, etc.
- To support, develop and contract referral options and resources to support the long-term management of MSK conditions.
- To provide advice, support, guidance and educational resources for GPs and other health professionals, ensuring that they are able to make accurate diagnoses and on-going management of patient care within GP practices
- To provide training and education opportunities for the future development of MSK professionals.
- To reduce follow-up rates in line with national benchmarks.
- To increase conversion rates for surgery.

Patient Aims:

- To provide patients with relevant and up-to-date information, enabling the patient to have the knowledge and ability to pro-actively manage their condition.
- To deliver consistent and streamlined care for patients.
- To improve health and wellbeing outcomes for patients.
- To ensure that patient's expectations are met through the use of patient management plans.
- To empower patients enabling them to make decisions about the care and treatments they receive.
- To treat patients at the most appropriate location but preferably as close to home as possible.
- To provide care and treatment for patients that fit with their lifestyle, minimising the impact on work and employment.
- To accommodate a variety of referral mechanisms: First phase to include GPand Health Care Professionals, second phase to pilot patient self-referral with a view to full-implementation.

3.2 Service description/care pathway

REFERRALS

The provider will establish appropriate protocols and referral mechanisms to enable referral as described below. These will be agreed with the CCG prior to implementation.

Self-Referrals:

The provider will phase in a pilot and implementation of appropriate mechanisms and processes to promote and facilitate an electronic on-line self-referral system; monitoring the use of the self-referral mechanism and addressing any barriers to its use. The self- referral will be designed to enable meaningful triage to the most appropriate service or advice and guidance for self-management. The self-referral will also identify "red flag" cases where the patient requires a rapid response.

The self-referral mechanism will be enabled for as many parts of the service provision as possible, however a number of areas may fall outside of self-referral; the provider will be expected to work with referrers to develop appropriate systems.

The service provider will have in place a communications plan to ensure that patients, public, GPs and practices and secondary care services are aware of and use the Triage service.

It is expected that the service provider will have the capacity to develop, flex and expand as local needs dictate.

GP Referrals

Wherever appropriate GPs should support patients to self-refer into the triage service. Where this is not appropriate, for example children, patients with learning difficulties, the provider should ensure that an appropriate electronic referral mechanism is in place for GP referral, for example EMIS / ERS.

Other Referrals:

Referrals may also be received from wider service provision for example, A&E and other community AHPs e.g. Nurse Practitioners, rehab teams etc. The provider should ensure that an appropriate referrals mechanism is in place, for example, EMIS or ERS.

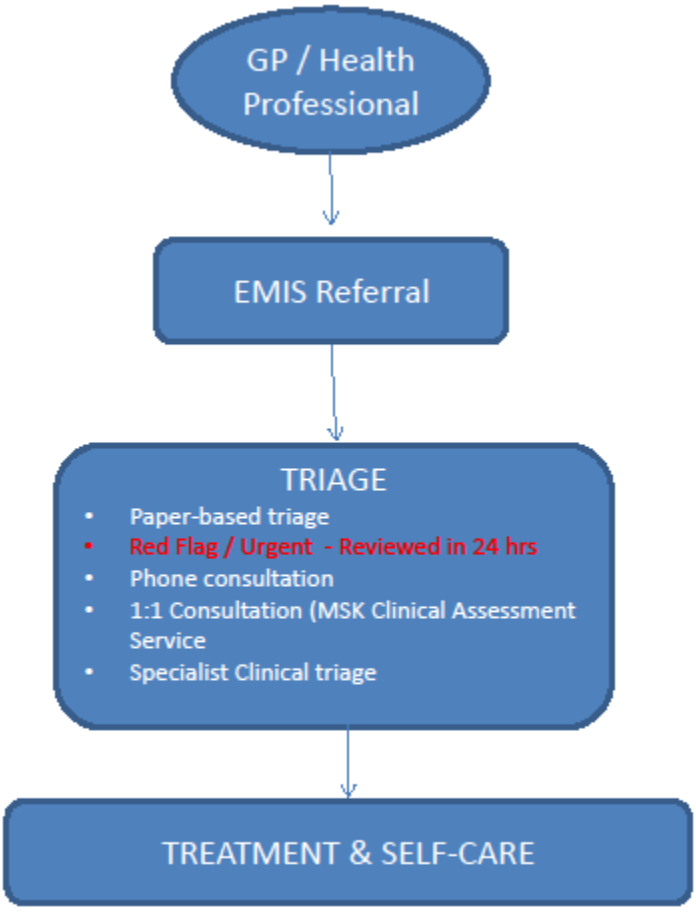
Referral

Initially all patients will be referred to the service by their GP electronically via EMIS.

In the longer term, a self-referral mechanism will be developed to enable patients to self-refer into the service, supported by their GP where appropriate.

All referrals for services within the MSK Integrated Triage Service will go via triage. The referral process will identify red flags for urgent consideration, these will be reviewed within 24 hours.

The triage service will be managed by advanced level physiotherapists, who will review referrals, ensuring that all diagnostic tests and assessments have been completed prior to treatment or self-care advice.



Red Flag Symptoms

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The provider must ensure that referral mechanisms allow for the prompt identification and processing of Red Flag symptoms as described below.

The provider must ensure that GPs have clear guidance to ensure that red flags are referred to the service appropriately and that emergency red flags, as defined below, are referred to the Emergency Department at WUTH..

The "red flags" were introduced in 1994 in the CSAG report. They comprise a number of symptoms and signs which have been associated with increased risk of underlying serious conditions. Recently some doubt has been cast on the sensitivity and specificity of the flags but they remain useful shorthand for clinicians to maintain awareness of possible serious pathology. Presence of a significant clinical suspicion of serious disease may lead to either:

Emergency Referral

- Suspected spinal cord neurology (gait disturbance, multilevel weakness in the legs and /or arms)
- Impending Cauda Equina Syndrome (Acute urinary disturbance, altered perianal and/or genital sensation, (reduced anal tone and squeeze – if circumstances permit)
- Major motor radiculopathy
- Suspected Spinal Infection
- Metastatic Spinal Cord Compression with neurological symptoms /signs

Urgent MSK assessment/ imaging

- Past history of cancer *
- Recent unexplained weight loss
- Objectively unwell with spinal pain
- Raised inflammatory markers (relative to range anticipated for age) Plasma viscosity , CRP , ESR
- Possible immunosuppression with new spinal pain (IVDU, HIV, Chemotherapy, Steroids).
- Prolonged steroid use *
- Known osteoporosis, with new severe spinal pain
- Age <15, or >60 years new onset axial back pain

*Statistically significant red flags. Although the others listed may not be statistically significant these are the ones which are commonly seen in serious pathology. The more of these present the greater the probability of serious underlying pathology

	Cancer	**Infection**	**Spinal fracture**	**Inflammatory disorder**	**Cauda equina**
Age at onset less than 20 or over 55 years					
Gradual onset before age 40					
Age over 70 years					

Unexplained weight loss (>10 pounds in 6 months)					
Previous history of cancer					
Tried bed rest but no relief					
Insidious onset					
Systemically unwell					
Constant, progressive, non-mechanical pain					
Recent bacterial infection eg UTI or skin infection					
Intravenous drug abuse					
Immunosuppression from steroids, transplant or HIV					
Significant trauma (minor in elderly)					
Prolonged use of corticosteroids					
Morning back stiffness > 30mins					
Peripheral joint involvement					
Persisting limitation of spinal movts in all directions					
Iritis, skin rashes (psoriasis), colitis, urethral discharge					
Family history of arthritis or osteoporosis					
Pain improves with exercise					
Acute onset of urinary retention or overflow incontinence					
Loss of anal sphincter tone or faecal incontinence					
Saddle anaesthesia					
Widespread (> 1 nerve root) or progressive motor weakness in the legs or gait disturbances					
Sensory level (altered sensation from waist down)					

The majority of patients without serious pathology have more than 1 positive red flag, and some red flags have very high false positive rates. An approach in which any positive red flag is acted upon will mean that there will be a large number of unnecessary referrals and investigations of patients. A better approach may be achieved by using a combination of red

flags that will identify potentially serious pathology while reducing the number of false-positive results (Henschke et al, 2009).

Henschke N, Maher C, Refshauge M, Herbert RD, Cumming RG, Bleasel J, Das A, McAuley JH (2009). Prevalence of and screening for serious spinal pathology in patients presenting to primary care settings with acute low back pain. Arthritis and Rheumatism. Vol 60, No 10, Oct 2009 pp 3072-3080

TRIAGE

The provider will provide a comprehensive and robust Consultant led triage system to ensure patients are quickly referred to the most appropriate treatment and care pathways, whether that be self-management, primary care or secondary care. The Triage Service is expected to comprise of two levels:

Level One - Referrals are reviewed by a team of Triage Physiotherapists and supporting administration staff who may undertake paper triage supported by telephone and 1:1 community based consultations., consul
Level Two - Complex cases are escalated to a multi-disciplinary Triage Team who hold specialist knowledge for the management and treatment of complex conditions.

Patients not accepted onto the service will be directed to the patient's GP.

All referrals will be screened and prioritised as routine or urgent by the Triage Service. Urgent cases shall be prioritised in accordance with evidence-based policies, developed by the provider, and in agreement with Wirral CCG to ensure patients are seen within a clinically appropriate timescale and priority is given to patients according to clinical need. Where appropriate the Triage Service will liaise with relevant GP practices to ensure relevant information is provided.

The triage team will identify and maximise opportunities for self-management through published information, tutorials, health promotion, health care, treatment and rehabilitation.

REFERRAL TIMESCALES

The triage service will process referrals on the following basis:

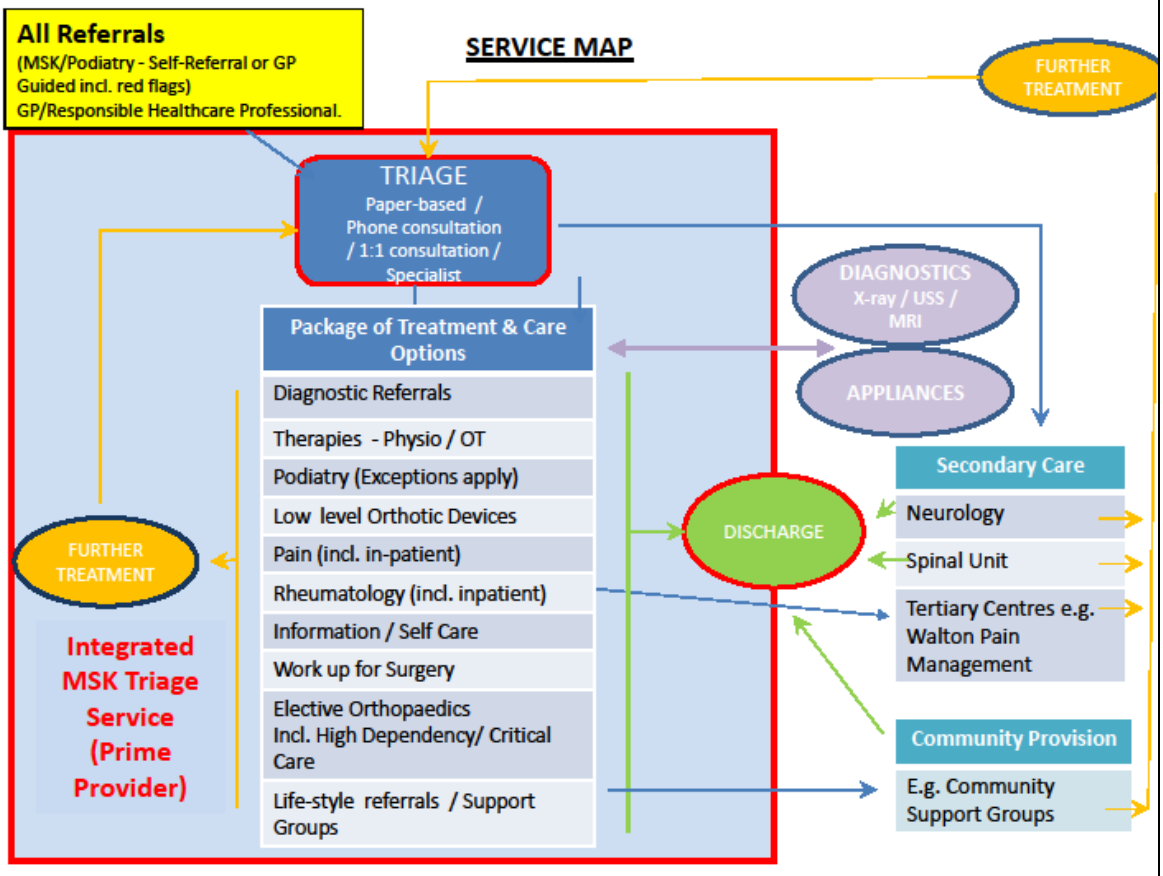
- Urgent Referrals within 1 working day
- Routine referrals within 2 working days
- If MCAS is required, this will be within 3 weeks from receipt of referral

For treatment following triage:

- Urgent referrals will be seen within 1 week of referral from the triage service
- For routine onward referrals from triage for treatment, the following timescales will be applicable:
    - Physio 8 weeks
    - Podiatry 4 weeks
    - Pain management 8 weeks
    - Orthopaedics 8 weeks
    - Rheumatology 10 weeks

OVERALL SERVICE DIAGRAM

This shows the overall service from referral to triage to treatment, demonstrating how patients would receive a menu of care and treatment. If this does not culminate in discharge, patient are directed back to triage for further review.



It is anticipated that the majority of patients will self-refer into the Integrated MSK Triage Service. (Physiotherapy, Pain Management, Rheumatology, Podiatry, Elective Orthopedic Surgery, diagnostic referrals). Other referrals may be generated by GPs, wider service providers, AHPs etc, as appropriate where patients are not able to self-refer or it may not be appropriate to self-refer (e.g. red flags).

The provider will be responsible for the triage and management of patients throughout their pathway through to discharge.

The provider will manage all community based services including triage, diagnostic referrals, therapies, podiatry, pain clinics, rheumatology, ICT based information to support self-care, work up for surgery / elective orthopedic surgery and life style support.

The provider will provide low level orthotic devices such as maternity belts, wrist splints, sacroiliac belts, heel cups, epicondylitis braces etc. The provider will refer to the CCGs appointed provider(s) for appliances where patients have more complex requirements.

The provider will access diagnostic testing through the CCGs appointed diagnostics provider.

It will be the provider's responsibility to implement extensive community based services, shifting services away from the traditional secondary care model, including primary/community care pain management, rheumatology and work up for surgery. Wherever possible the provider will implement strategies for self-management through the use of information and tele-support, maximising ICT based solutions.

Patient Care and Treatment

Individual Care Plans

In conjunction with the patient, individual care plans will be agreed and patients directed to the most appropriate service for their needs. This may include a planned pathway through a range of service provision, or longer term condition management. The consultant led triage service will monitor individual patient progress, providing GPs with periodic updates, and referring patients to further services as appropriate until the patient is discharged.

There will be two different types of care plan:

- A Personalised Care Plan – for patients receiving episodic, short term care in order to treat an acute or time limited condition, for example an ankle sprain, a referral for knee replacement, or an episode of low back pain

- An Enhanced Care Plan - for patients with a long term condition, expected to remain under the care of the MSK Integrated Service for a longer period without a predefined discharge date, for example a patient with Rheumatoid Arthritis who requires stabilising on medication.

The provider will establish suitable mechanisms to track patient treatment and referrals, to monitor individual patient progress, to report progress to GPs, and to identify any areas of duplication or waste.

Patients will be seen and treated in the most appropriate setting for their needs. This may include hospital and / or community based service or via telephone / IT based contact for advice.

In addition to a Physiotherapy Consultant led triage service, the service will provide outpatient physiotherapy, podiatry, pain management and rheumatology. Developing assessment and therapeutic interventions based on individual need, utilising a range of delivery mechanisms which may include group or individual therapy, web based guidance and published support materials.

The service will identify and work with a wide range of providers to address the contributory factors of MSK and promote self-management, this could include Lifestyle services, Physical activity, Support groups, Mentoring services and psychological support, Leisure Services.

The service will signpost patients to wider support agencies to address wider issues affecting patients, for example, Job Centre Plus, Ask Us Wirral, Tomorrow's Women, Advocacy In Wirral.

Carers

The integrated MSK service will engage with, and support, carers at all stages of the patient pathway. The team will develop a carers information pack and have access to a diverse range of support services to which carers can be signposted.

Treatment Services

The service will provide a variety of self-management and treatment services appropriate to patient's needs, including:

- Self-management advice – provided through digital resources, hard copy resources, telephone support, promoted throughout the patient journey as appropriate.
- Injections – where these can be provided within a community setting and in line with Wirral's Procedures of Lower Clinical Priority (PLCP) policy. (NB. An NHSE commissioned community based service currently operates through GPs; the service should establish links with GPs and offer patients GP based joint injections where available. All other injections will be provided by the service).
- For physiotherapy patients, assessment and supply of low level orthotic devices such as maternity belts, wrist splints, sacroiliac belts, heel cups, epicondylitis braces etc.
- Physiotherapy including manual therapies and osteopathy.
- Occupational therapy
- Podiatry
- Medication prescribing by physiotherapists – pilot a physio prescribing service with a view to full implementation
- Rehabilitation programmes and services, e.g. Functional Restoration Programmes (FRP), Osteoarthritis Knee Group classes, hydrotherapy services. These should include evidence based group sessions which promote shared decision making and supported self-care.
- Psychological therapy for patients with persistent pain both in an individual and group setting, i.e. pain management programme. Eg spinal
- Consultant led multidisciplinary pain management service offering medication, assessment and treatments appropriate for individual patients;
- Consultant led multidisciplinary rheumatology service offering assessment, treatment and, if clinically appropriate, on-going follow up and medication under agreed shared care arrangements with the patient's GP
- Elective orthopaedics surgery including assessment, patient optimisation, work up and joint school
- Minor operative procedures within clinically appropriate settings
- Referral for diagnostics and assessment of results

At every stage of the journey, treatments will be evidenced based and follow appropriate regulations and guidelines.

The provider is responsible for all aspects of service delivery whether directly provided or sub-contracted.

The following sections describe each service in more detail:

DIAGNOSTICS

The term 'diagnostics' refers to any investigative tests or imaging carried out to aid and support the identification and extent of the patient's condition. A range of diagnostic tests and imaging of varying complexity will be required to support clinical assessment and care within the service.

The provider is advised to utilise the existing diagnostic service pathways to undertake the required diagnostics.

Existing pathways to diagnostics include:

X-Ray
Pathology, biochemistry, microbiology, haematology and immunology
MSK ultrasound / Ultrasound
MRI
DXA
Nerve Conduction Studies*
CT
Nuclear medicine

*the provision of NCS are the responsibility of the provider.

This list is not exhaustive and should be reviewed on an on-going basis by the provider, in order to continually meet best practice and NICE guidance.

The provider will be responsible for all relevant referrals to diagnostics, ensuring that they are timely and appropriate, that there is no duplication of diagnostics and that appropriate records are kept and available as required throughout the patient's pathway. Where GPs are ordering tests (e.g. tier 1 pain management), the service will provide support and education to ensure appropriate testing.

From April 2018, all MRI tests for MSK conditions will be ordered via the triage service rather than GPs.

From April 2018, all Nerve Conduction Studies will be ordered via the provider.

The provider will keep comprehensive records of diagnostic tests undertaken, and provide evidence to support the appropriateness of each test in line with published guidance. The provider will be expected to evidence reduction in the number of diagnostic tests being order, particularly in respect of duplicate tests.

PHYSIOTHERAPHY

Aims:

- To deliver a community physiotherapy service across primary and secondary care
- To promote self-care and self-management through patient information including leaflets, IT based support, apps and videos
- To provide a 7 day service including evenings where appropriate
- To provide a high quality service for patients which is timely, equitable and available to all within the community and across all sectors (within primary care, care home, hospital, intermediate services) as appropriate and to include;
  - Specialist therapy assessment, advice and treatment
  - Community and Practice based physiotherapy
  - Hub (centre)physiotherapy
  - Housebound service (NB this does not include referrals that would be provided through Rehab at Home/STARS/IMC) (see Housebound Criteria in Appendix 3)
  - Acupuncture if clinically appropriate (for MSK) (NB Do not offer acupuncture for managing low back pain with or without sciatica- NG59).
  - Physiotherapy post-surgical pathway (requires further therapy)

Objectives:

- To provide care closer to home
- To promote self-care and self-management
- Provision of timely community physiotherapy
- Choice of appointments
- Enable quality clinical outcomes e.g. functional outcomes, pain scores, quality of life (SF36 or EURO QoL) as part of restoring function, physical ability, preventing deterioration
- Quality patient experience with promotion of self-care, well-being (Patient Reported Outcome Measures -PROMS) and increased levels of independence
- Reassessment as part of a continuum of care (agreement with GP)
- Reduction of inappropriate attendance and unnecessary avoidable admissions to secondary care
- Early discharge from attendance at secondary care services i.e. A&E, Fracture Clinic, Orthopaedic Services (list not exhaustive)
- Early identification of patients at risk or with an increased risk score in order to proactively manage with appropriate interventions
- Reduce Did Not Attends (DNAs)
- Provision of walking aides and other appliances as appropriate
- Appropriate referral for equipment to other community services
- To support the Quality, Innovation, Productivity and Prevention (QIPP) agenda

Service Description / Care Pathway:

The service must deliver extensive physiotherapy support as follows (list is not exhaustive);

- Outpatient Hub and practice based physiotherapy, particularly MSK to include
  - Upper limb
  - Lower limb (to include orthotic assessments and heel raises)
  - Spinal
- A&E physiotherapy for minor conditions
- Physiotherapy for sprains, strains, other limb problem, which is not a fracture
- Post-surgery physiotherapy, hip, knee, shoulder etc (supporting enhanced recovery pathways),outside of original commissioned pathway
- Specialist spinal physiotherapy (not pain service)
- Specialist MSK physiotherapy with access to advice/support for ongoing management as appropriate
- Osteopathy for specific, appropriate patients
- Paediatric MSK physiotherapy for example sprains and strains
- Multi-disciplinary team rehabilitation to support intermediate care
- Women's health physiotherapy, to include ante/post-natal service, continence care, and women's health musculoskeletal problems, related specifically to pregnancy and childbirth such as pelvic girdle pain, perineum tears such as 3rd degree tears
- Neurology physiotherapy (Multiple-sclerosis, Stroke (excluding early supported discharge), Motor neurone disease, Acquired Brain Injury, early onset dementia)
- Conditions for life - to include yearly review for Multiple-sclerosis and Parkinson's disease patients
- MSK physiotherapy for cancer and palliative rehabilitation.
- Hydrotherapy for specific, appropriate patients were land based exercise has failed and following appropriate assessment for a hydrotherapy pathway
- Respiratory physiotherapy for appropriate patients presenting with chest infection/chest symptoms
- Acupuncture for patients where it is deemed appropriate as part of their management (NB Do not offer acupuncture for managing low back pain with or without sciatica- NG59).

The service will be available 7 days a week, including evenings to accommodate patient choice. Locations and hours will be agreed with Wirral CCG. The service must support self-management, quality of life and health and wellbeing promotion.

The provider will ensure appropriate tools are used to support the assessment and delivery of physiotherapy, for example, Keele STarT Back Screening Tool (SBST), all tools must be approved by a recognised body e.g., the Chartered Society of Physiotherapy.

Practice based physiotherapy must include an option to consult with specialist physiotherapy (within the hub) regarding further management if required. Specialist MDTs must be in place to discuss complex patients, with input from wider disciplines. MDTs should also be a forum to enhance skills and knowledge of clinicians, to promote teamwork and increase access to wider knowledge and expertise.

The service must offer and deliver 1:1 appointments or group therapy/classes, as appropriate to meet the needs of the patient. Group therapy sessions should be maximised wherever possible and will have no more than 10 patients per group.

Maximum wait time for all patients to be seen is within 8 weeks. Appointment confirmation will be sent to the patient.. Follow-up appointments must be booked with the patient wherever possible to reduce the number of cancellations. Appointment length will be appropriate to the needs of the patient.

Patients referred into the service will be assessed, treated/managed and discharged in line with current guidance. Conditions will be managed according to clinical appropriateness. Care plans and Treatment summaries will be sent to the patients GP detailing the patients problem, treatment agreed, estimated number of sessions (where possible) and whether the patient is co-operating with self-exercise plans etc.

The provider will empower patients to maximise their potential and independence, providing appropriate education to support this. Early senior input from specialist physiotherapy for complex cases is encouraged and must be supported by the provider to commence as early as possible within the treatment pathway.

The provider will ensure all appropriate details are communicated to the necessary recipients and appropriate notes are made in the patient's records. The provider will report a patient's clinical progress and management plan to their GP within 5 working days of discharge. The provider will be responsible for ensuring the accuracy of this information and medication notifications. If a patient is under the care of a hospital specialist, they will also receive a copy of the report(s).

All patients will be discharged as per the MSK Integrated Triage Service discharge policy.

Certain conditions may require longer term care plans / open-ended management plans to support the continuum of care. These include:

- progressive long-term neurological conditions e.g. Supranuclear Palsy, Motor Neurone Disease, Parkinson's Disease, Multiple Sclerosis, Disabling Brain Injury, Cerebral Palsy, Congenital Orthopaedic Disease.
- Complex fractures
- post-operative, major trauma, significant back pain (if Startback score indicates medium to high risk)*
- children's feet
- juvenile idiopathic arthritis
- multiple morbidities
- children MSK

- or in agreement with patient's GP and patient/carer for open-ended management supporting the continuum of care.

The above list is not exhaustive.

Patients shall be referred without delay to their GP and the triage service, if there is a progression or deterioration in their condition requiring further assessment. All suspicious findings will be communicated immediately (no later than same day) by phone to the referring GP and the triage service for urgent/immediate action.

The provider is responsible for ensuring all staff are aware of the role of equipment in supporting patient goals and the need for appropriate referral only to the equipment service. Evidence of equipment provision for supporting rehabilitation goals must be documented. Staff working within the service must have an understanding of the impact of equipment provision within the wider healthcare economy.

In addition to patient advice leaflets and Web based information / apps, the provider must provide a contact number for patients and carers, with link to clinical staff where appropriate.

The provider will ensure dignity and respect of patients is demonstrated at all times. This includes offering choice of female or male physiotherapy staff to accommodate patients' wishes.

The service will be fully inclusive of all patients, communities and cultures, including people with learning disabilities and mental health problems. The provider will produce appropriate high quality patient education and information, both verbally and written and will provide patient education literature at each stage of the care pathway. This will include advice leaflets, DVD, visual tools, website for patients. The provider will produce all patient information and literature in different languages and formats to represent the Wirral community. The provider will facilitate a group approach including expert patient involvement where appropriate and support carers as required.

The provider will work proactively to minimise Did Not Attends (DNA) appointments. This will include providing appointment reminders, such as a text service to reduce DNA rates.

MINOR PROCEDURES & NON-ORTHOPAEDIC SURGICAL INTERVENTIONS

Minor procedures appropriate to be carried out by the service shall be those which can be performed in a clean treatment room environment, and in line with current Healthcare Commission guidance. The provider will be expected to offer appropriate treatments dependent upon the needs of patients using the service.

Non-orthopaedic surgical interventions provided by the service will typically be confined to those procedures categorised as minor, 'clean room' treatments, and not requiring an overnight stay. Treatment may also consist of a variety of therapies and other non-surgical interventions. There must be an evidence base for all treatments offered within the integrated community service. These should also comply with all relevant NICE guidance and other clinical best practice.

The list below shows a range of treatments identified by the Healthcare Commission as being appropriate for clean treatment room setting. This is not an exhaustive list and is intended as an indication of possible treatments appropriate for the community service:

- Intra-articular injections
- Epidurals
- Manipulation
- Aspiration of knee/joints
- Nerve root blocks

- Other minor surgery

The Wirral Policy for Procedures of Lower Clinical Priority (PCLP) will apply to the above.

ELECTIVE ORTHOPAEDIC SURGERY

The service will identify and undertake all elective orthopedic surgery for patients, specifically it will:

- Ensure patients listed for surgery are appropriate and that all other interventions have been exhausted
- Ensure patients listed for surgery are at optimal health in order to achieve the best outcomes from the surgery, use joint school to support patients with their surgery.
- Undertake the fitness for surgery assessment; first line consenting, discharge planning and Enhanced Recovery processes prior to the surgical procedure taking place.
- Ensure specialist advice is in place for patients where appropriate, for example, Bariatric advice, specialist plastic surgery input.
- Where patients require specific interventions prior to surgery, for example weight loss / smoking cessation, the service will refer the patient and discharge the patient to primary care. Once the intervention is complete, the patient will self-refer back into the service to progress orthopaedic surgery as appropriate.
- Support patients with queries or issues relating to their surgery.
- Develop an agreed timely discharge plan.
- Conduct 5 & 10 year knee and hip reviews post-surgery
- The service will ensure all Orthopaedic Surgery is in line with national guidance, for example, NICE, British Orthopaedic Association.
- The provider will ensure onsite high dependency and critical care provision in line with NICE guidance is available

PODIATRY

The provider is required to provide the full spectrum of podiatric care, however utilising case studies available through NICE (http://www.evidence.nhs.uk/qualityandproductivity - Podiatry education to empower patients to self-care), the provider will introduce self-management initiatives for the majority of Tier 1 services. Identified exceptions to this include Diabetes management and nail surgery procedures. (see Appendix 1 for a breakdown of these services)

- **Tier 1** – Core Podiatry – Low to Medium Levels of Foot Health Need (provided through self-management with the exception of Diabetes management and nail surgery).
- **Tier 2** - Specialist Podiatry – High Levels of Foot Health Need
- **Orthotics** - Biomechanical Assessment, Advice and Provision of Foot Orthoses.

If patients require onward referral to secondary care from community podiatry for active disease of the foot, the provider must follow local guidelines in place for the following conditions:

- Diabetic foot ulcer
    - Patients presenting with diabetes related foot ulceration must be referred to WUTH diabetes foot clinic within 24 hours using the embedded referral form

Diabetes Foot
Ulceration Referral Fc

- Peripheral vascular disease with or without ulceration
    - Referral to either a vascular surgical unit for assessment, or to the Diabetes MDT.

- Charcot foot
    - Referral to the Diabetes MDT within 24 hours.

- Painful peripheral neuropathy
    - This can be supervised in general practice, provided that the GP is confident that the neuropathy is the cause of the pain or referral to an MDT may be necessary for assessment.

- Disease of the foot unrelated to diabetes, should be managed appropriately.

The service provider is responsible for the monitoring of patients discharged from secondary care to community podiatry. The provider must ensure that a shared care approach/two way communication is in place between community podiatry and secondary care to support any changes in podiatric condition and referral back to secondary care as clinically appropriate. Evidence shows that patients' who have a history of foot ulcers are susceptible to developing subsequent ulcers. This supports the need for regular monitoring by community podiatry.

The service provider is to apply a 'one-stop-shop' approach (where appropriate and where possible) with regards to undertaking biomechanical assessments and the provision of simple and/or custom made foot orthoses. Where this is not available, the provider should refer patients onwards as appropriate or arrange a follow-up appointment.

Domiciliary wound care should be managed on a shared care basis with community nursing or secondary care as applicable.

The service provider must undertake annual reviews of diabetic patients classed as 'at risk' or 'high risk' who have been referred into the service and ensure that an effective recall system is in place for the recall of annual diabetic foot checks and reviews. In order to realise the maximum benefits for diabetic patients, podiatry clinics should co-locate with the diabetic community hubs as appropriate and resources made available to support MDT foot clinics. The service must ensure that an appropriate number of specialist diabetic podiatrists are available within the service.

LIFE LONG CONDITIONS

Patients with the below Life Long Conditions would be expected to stay within the service with an effective monitoring and recall system in place.

- Increasing risk and high risk diabetics
- Rheumatoid arthritis patients
- Multiple sclerosis patients
- Peripheral vascular disease patients
- Connective tissue disorders
- Systemic auto immune disorders
- Neurological conditions
- Disability

PAIN MANAGEMENT

Background:

The British Pain Society National Audit (November 2011)[1] describes pain as "a complex bio-psychosocial experience". Pain that persists longer than expected can be difficult to accept, and, therefore, to treat. Whilst most people are able to manage their pain successfully, some require referral to specialist pain services. The definition of a specialist pain service for the purpose of coding in the UK is described as the diagnosis and management of complex pain disorders, requiring a multidisciplinary approach". The British Pain Society National Audit estimated prevalence of chronic pain at 6.4%, annual incidence of 8.3% and annual recovery of 5.4%.
Research evidence and the resultant policy guidance that has emerged in the last 30 years for pain services in the UK have clearly indicated that the most effective approach for pain services is multidisciplinary working[2, 3, 4, 5].

Recent health policy has encouraged the move for such services from traditional settings in specialist secondary care centres, into a community setting. The White Paper 'Our Health, Our Care, Our Say: a new direction for community services' included recommendations around early intervention, improved access to community-based services, a commitment to address inequalities of care and to move services closer to peoples' homes. These recommendations were accompanied by an expectation that the relocated services would improve the patient journey, result in cost-savings and achieve similar treatment outcomes.

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References:

1. National Pain Audit. Phase 1 Report: Organisational Audit of NHS Chronic pain Services, British Pain Society and Dr Foster Intelligence
2. Eccleston. C., Williams, A. C. de C., & Morley, S. Psychological therapies for the management of chronic pain (excluding headache) in adults. Cochrane Database of Systematic Reviews 2009, Issue 4 Art.
3. Flor, H., Fydrich, T., & Turk, D. C. Efficacy of multidisciplinary pain treatment centres: a meta-analytic review. Pain 1992, 49:221–230.
4. Morley, S., Eccleston, C., Williams, A. Systematic review and meta-analysis of randomized control trials of cognitive behaviour therapy for chronic pain adults, excluding headache. Pain 1999, 80:1–13.
5. The British Pain Society. Recommended Guidelines for Pain Management Programmes for Adults 2007.

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Pain Management - Service provision:

The service will promote long-term self-management and less dependency on the wider health care services such as: A&E, GPs, secondary care, ambulance services and mainstream physiotherapy.

Pain management services should be delivered through a three tier system (described in full in Appendix 2):

- Tier One - primary care services from GPs, community pharmacists, pain self-help organisations/groups and community based physical therapy;
- Tier Two - community services offering pain management programmes, IAPT (Improving Access to Psychological Therapies) services, web based and paper based self-management resources, signposting to pain self-help organisations/groups and community based physical therapy and; pain management programmes inc CBT
- Tier Three - secondary care service for patients with complex needs or pain relief that needs to be delivered in a secondary care environment.

The provider will be responsible for the delivery of a comprehensive Tier Two and Tier three service.

The Tier two service will consist of a multi-disciplinary team that can manage patients' physical, psychological and social needs associated with pain. It will ensure patients experiencing chronic pain are appropriately managed in a community environment and for those patients requiring secondary care (tier three), to be managed in an appropriate hospital setting when they need

specialist interventions: transferring back to a community setting (if necessary) once Tier 3 intervention is complete.

The service will act as a single point of access for patients referred with chronic pain of at least 3 months duration with an acceptance that the pain has become chronic pain and is not of a short term nature.

The provider shall provide a community based pain management service that:

- Supports and empowers patients through shared decision making to gain or regain self-belief and confidence.
- Reduces dependency on healthcare systems and enhances the quality of life for service users and carers/families.
- Offers improved access to high quality pain interventions which will include education, physical therapy and psychological support that improve health and wellbeing.
- Works with, and educate, clinical colleagues to safely optimise the use of analgesia and self-management tools and techniques.
- Works with a range of different organisations including the contract parties, local authorities, private and voluntary sectors.

The objectives of the community based pain management service are:

- Act as a single point of access for patients with chronic pain.
- Support the referring clinician/health professional in identifying and actively managing patients at high risk of chronic pain becoming chronic.
- Provide a bio-psychosocial assessment to patients referred with chronic pain (i.e. of at least 3 months duration).
- Use shared decision making to deliver support and programmes to patients living with chronic pain enabling them to understand and come to terms with their pain.
- Enable patients to take ownership and to adopt strategies of living, which allow them to lead as fulfilling and independent lives as possible with less reliance on the health care system.
- Educate and support other health care professionals in the early intervention of pain management techniques and encourage collaborative and cross boundary working with other contracted parties.
- Reduce elective care activity within acute hospital setting.

The service will deliver and evidence the following key outcomes:

- Quantifiable improvements in the patient’s perception of their pain.
- Evidence of patients self-managing their condition.
- A reduction in the use of medication (if appropriate) and/or optimisation of medication use.
- Fewer patients in the Wirral requiring referral onto secondary care pain (internal service referral and GP referral) through earlier recognition and management of patients developing chronic pain.

• A positive outcome in their physical, psychological and/or social needs.

• An increase in individual's self-reported levels of physical and social functioning in society

RHEUMATOLOGY

The community based service will comprise of Consultant Rheumatologists and their teams working within the Integrated MSK model, with seamless interfaces with primary care, local voluntary sector support groups and wider hospital based services.

The service will be:

- In line with national guidance including NICE guidance and that published by the Royal College of Physicians on the management of rheumatoid arthritis.

- Delivered on the common understanding that the patient will remain under the care of a named consultant rheumatologist until discharged from specialist care. This is to ensure the continuity and quality of care delivered by all members of the local specialist rheumatology team.

Components of the service:

- GPs access to urgent specialist advice within 2 working days, along with routine advice and guidance services. The Service will support and encourage GP education on Rheumatological conditions particularly with respect to early diagnosis and referral on suspicion of inflammatory arthritis.

- There will be a One Stop assessment, diagnostics and initiation of a management plan.

- Once the diagnosis has been established, a documented baseline assessment should be carried out that includes the patient's general medical health and co-morbidities

- Within four weeks of diagnosis, patients should be offered the opportunity to talk to a member of the specialist rheumatology team to enable a more in depth discussion about the diagnosis, treatments and the ramifications for them on a personal level.

- Patient information – the service will encourage and enable supported self-care wherever possible through providing patients and cares with access to support information, advice and support services through a variety of media. This will also include signposting to wider support services throughout the pathway.

- Patients will have access to a multidisciplinary Rheumatology Team in the form of Consultants, GPwSIs and Nurse Specialists alongside other allied Health Professionals within the MSK Service, e.g. physiotherapists, podiatrists, occupational therapist with care provided as far as possible as a one stop shop

- Patients can be referred seamlessly if clinically appropriate to other Specialised Services within the MSK Service e.g. Orthopaedics, Pain Management.

- All patients should be informed about how to contact a named member of the specialist rheumatology team in the event of a 'flare-up' or if they have a specific area of concern.

- Access to telephone follow up where clinically appropriate.

- Provision of agreed evidence based treatments in the form of medication according to agreed formularies with the Medicines Management Team.

- Provision of agreed evidence based treatments that can be carried out in a clean Treatment Room e.g. Joint Injections.

- Seamless referral into Secondary Care Providers for Specialist Inpatient Care and Day Care.

Inflammatory Arthritis:

- Rapid access to specialist opinion within 5 working days of receipt of referral for all patients with possible (non Osteoarthritis) inflammatory arthritis

- One stop assessment, diagnostics and initiation of management plan

- Patients with a diagnosis of Rheumatoid Arthritis will have received their first treatment within 6 weeks of referral

- Post diagnosis, patients with inflammatory arthritis will be offered an appointment within four weeks of the diagnosis to discuss the diagnosis and the ramifications of the condition further with a member of the specialist rheumatology team

- A comprehensive annual condition specific review in line with NICE Guidance by a member of the specialist rheumatology team (ideally one who has treated the patient for most of the preceding year). This could also include an MDT review

- All patients with inflammatory arthritis should have access to an annual health screen that includes a full cardiovascular risk assessment in accordance with the BSR guidelines

- Those patients who have Rheumatoid Arthritis will have monthly assessments if their DAS28 score is > 2.6 and will receive rapid escalation of treatment in line with NICE Guidelines until their EULAR DAS28 defined remission of DAS28 < 2.6 is achieved

- All patients with inflammatory arthritis on a stable management plan should be reviewed by the Consultant every 2 years

- There should be arrangements for the transitional care when children transfer from paediatric to adult care

- Patients with the less common, but important inflammatory multisystem rheumatic conditions will also require similar access to the specialist rheumatology team and the foregoing standards, even if arthritis is not the main part of their condition.

Ongoing care:

The key features of ongoing clinical care for all patients seen within the rheumatology element of the MSK service include:

- The development of agreed shared care protocols that facilitate joint working, follow up, medication prescribing and monitoring between general practice and specialist clinicians

- A much greater emphasis on supported self-care for patients and their carers throughout the patient pathway

- Patient access to telephone follow up where clinically appropriate

- For those patients that clinically require DMARDs and on-going follow up within the Rheumatology MDT, development of agreed shared care protocols that facilitate joint

working, follow up, medication prescribing and monitoring between general practice and specialist clinicians

- For those patients that clinically do not require on-going follow up by the Rheumatology MDT (ie not on DMARDs, do not have chronic inflammatory arthritis), they are discharged to GPs with an agreed shared care plan describing the patient's on-going self-management that is held by the patient and GP.

- An electronic discharge summary detailing diagnosis, investigation results and management plan will be received by the GP within 3 days of discharge

Discharge from the Integrated MSK Service

- The length of time the service will support a patient with their MSK condition should be discussed with the patient and clearly documented in the patient's management plan.

- The service is expected to discharge patients once their package(s) of treatment are completed. For patients requiring specific interventions before orthopaedic surgery, for example, weight loss / smoking cessation, a referral will be made to the relevant provider and the patient discharged to GP. Once the intervention is complete the patient will be able to self-refer into the triage service to progress orthopaedic surgery.

- Provision must be made for patients to re-access the service in circumstances where their condition deteriorates or reoccurs and the patient is unable to self-manage.

- The provider will be responsible for ensuring that the referring GP and the patient is sent a typed discharge summary letter outlining the following:-

    - Diagnosis
    - Interventions
    - Treatment plan
    - Progress made by the patient
    - Patient advice given in relation to next steps, including self-management or onward referral to another professional or organisation.

- This discharge summary letter should be sent electronically to the referring GP and by post or electronically to the patient within 5 working days of discharge from the service.

- Where the provider is discharging patients to the care of the GP. e.g. pain management, patients should be discharged with a clear pain management plan. This should include clear information on how to self-manage their condition, how to access services in the community and how to gain future access to the Integrated MSK Service, as appropriate.

- If the patient requires a referral to a secondary care provider, the provider must ensure that the patient has been offered a choice of provider and is referred using the appropriate local system (NHS E-referral Service). The provider must then ensure that a discharge summary is sent to the provider with the onward referral and that the patient's GP is informed of the referral. If surgery is required, the provider will ensure that relevant diagnostic tests have been taken and their results forwarded to the surgery provider prior to the patient's first appointment with the surgery provider. If after secondary care review, further MSK treatment is required, the patient will return directly to the MSK service without the need for GP referral.

If the patient requires referral to another service outside the scope of the MSK interface service, the GP will be notified within 2 working days and the patient will be directed to return to their GP.

- For complex patients, an ongoing management plan and an SOS system must be in place to enable patient access back into the service within an appropriate time framework.

- For patients who may experience flare-ups, for instance, in rheumatology, a SOS system must be in place to enable patients to receive appropriate advice and access back into the service as appropriate.

- The service will monitor and evaluate the reason for failed discharges; these are defined as any patient re-referring back into the triage service within 12 months for the same condition. Where appropriate changes to services will be made to address and minimise failed discharges.

DNAs and cancellations
The provider is expected to establish, and agree with the CCG, a policy to manage DNAs and cancellations.

Patient Participation
The provider will work with patients in ways that foster partnerships and include patient view on:

- location and access to services
- treatment and outcome
- support received around self-management
- information provided regarding their condition
- overall satisfaction

The provider is expected to demonstrate a variety of patient partnership approaches including working with third sector and local communities and establishing service user groups and demonstrate how user feedback is incorporated into the improvement cycle.

Prevention & Self-Management

The provider will be a key deliverer of the prevention and self-help agenda for MSK, rheumatology, pain management and podiatry on the Wirral. This includes working with partners, e.g. Public Health, Leisure Services and community groups to promote initiatives to increase the health of the population resulting in a decrease in MSK, rheumatology, pain management and podiatry disorders being seen by GPs, the integrated MSK service and subsequent referrals.

This could include communications campaigns, healthy living talks, targeted activities and workshops for identified high risk groups.

The provider will develop digital resources to support prevention and self- help. This will be accessible for the whole population and will support reduced referrals and re-enforce the advice and guidance given within the care package.

Shared Care

The service will provide elements of a shared care model whereby patients who are stable can be managed by their GP with advice and education available from the Integrated MSK Service to support up-skilling and primary care management.

The service with work with GP practices to ensure that patients discharged for Shared Care are discharged with all appropriate management information in place.

Innovation

- Innovative approaches and treatments should be encouraged as appropriate for patients
- Clinical trials, where appropriate should be encouraged
- Consideration of home treatments as appropriate should be embedded into te service
- Innovative methods to promote self-management are expected to be a fundamental aspect of the service.

3.3 Population covered

- Service recipients will be patients who are registered with GP practices within the boundary of the Wirral CCG area.
- The age range for the service is for age 16+, with the exception of MSK Physiotherapy who will also assess and treat children under 16 years.
- The service will deal with all issues related to age, gender, sexuality, culture and disability sensitively. Where language/cultural issues are evident, the appropriate external sources must be mobilised by the provider, e.g. language and interpreting services.
- The service will operate within organisational policies which are Impact Assessed to ensure equality and diversity issues are highlighted and monitored.
- The MSK integrated service should work within the following values:-
    - Respect the dignity, privacy, confidentiality and diversity of patients through an open and supportive organisation.
    - Champion vulnerable people through equity and fairness.
    - Be a good employer demonstrating commitment to staff development, involving and engaging the workforce.
    - Play an active part in the development of the whole community ensuring services are approachable, accountable and inclusive for all members of that community.

3.4 Location / Physical Assets / Equipment

Services should be available from a number of community based locations such as; GP practices, community locations, patients' homes, care homes, secondary care and hospice, where appropriate Locations must be reflective of the needs of the local population. Sites must:

- Comply with appropriate health and safety legislation
- Have disabled access
- Have sufficient waiting and treating areas equipped with the necessary equipment
- Adheres to infection control best practice
- Suitable parking for patients
- Accessible by public transport within a five minute walk

Locations to be agreed with Wirral CCG.

Patients should be able to choose their preferred location and the service should operate opening and closing times that meet the varying needs of patients. This will include evening and weekend provision.

The provider is responsible for all aspects of accommodation ensuring it is appropriately furnished and equipped.

All venues must be compliant with the Disability Discrimination Act.

Co-located services should be in place where there are benefits to patient care, for example, within diabetes community hubs, one stop shop type facilities

On-site high dependency and critical care units are a key requirement for secondary care

3.5 Any acceptance and exclusion criteria and thresholds

Exclusions:

- Under 16's except MSK physiotherapy which includes children Under 16's except MSK physiotherapy and Podiatry which includes children.
- Complex children - 0-4 years with conditions which effect their mobility or neurological development such as CP, downs syndrome etc, 4-19 year old children and young people with a range of conditions which significantly affect their mobility or physical health.
- Acute trauma and injuries
- Fracture Clinic Services
- Suspected cancer referrals and cancer treatment
- Provision of specialist equipment and/or modifications to patient housing
- Tier 1 Pain Management Services Appendix 2
- Intermediate Care Services
- Patients requiring personal foot care (defined as toenail cutting and skin care) that are capable of carrying out as part of their everyday personal hygiene
- Forensic podiatry

3.6 Interdependence with other services/providers

In order to provide the most appropriate treatment and care for patients, the service provider will be required to :

- Contract and manage services that deliver treatment pathways for patients being managed by the Integrated MSK service. This includes physiotherapy, rheumatology, podiatry and pain management.

- Develop relationships with an extensive range of providers and service area

- Provide educational programmes and support materials to GPs and health professionals where these will enhance the patients care pre, during and post treatment.

- Develop new pathways and services where these present an appropriate and cost-effective solution for the treatment of patients.

The service provider will develop links with a variety of providers linked to the MSK pathway, this include:

- Primary care
- Community Service providers
- Diabetic Clinics
- Orthopaedics
- Neurosurgery
- Psychology services
- Emergency Services
- Volcom Sector / Support organisations
- Local Authorities
- Intermediary Care

In addition, the provider will develop excellent working relations with organisations who are at the source of referrals, ensuring these organisations have a clear understanding of the service provision and that the service proactively meets their needs.

3.7 Staffing

The MSK Integrated Service will be physio consultant led and supported by registered clinical practitioners as appropriate to the scope and objectives of the service. This will include access to GPwSI, Physiotherapists, Psychologists, extended scope practitioners and other health professionals drawing on a wide range of clinical assessment and treatment skills.

- For medical staff, full registration with the GMC and indemnification will be required. Clinical accountability will be via the medical director of the employing authority. GPwSIs will be accredited by the relevant deanery. A GPwSI mentoring programme should be established.

- Other practitioners will hold state registration and insurance. They will be able to demonstrate specialist clinical knowledge and experience. Practitioners will have enhanced skills in relevant clinical areas and multi-disciplinary working. They will have professional management and accountability within their employing organisations.

- The skill mix for the service and the core team will be determined by the provider, however it is expected that the multidisciplinary input available to the service would consist of the following: medical, physiotherapy, clinical psychology , occupational therapy, pharmacy/ medicines management, rehabilitation support worker, dietetics, anaesthetics

- There must be identified and clear clinical leadership and multidisciplinary leadership within the service

- The service will be adequately staffed and properly managed to ensure consistency and continuity of care to patients.

- Appropriate time must be built into staff contracts to permit them to have protected learning time and enable attendance at mandatory training.

Service providers must be able to demonstrate they have a robust recruitment, induction and training programme which ensures that all staff employed within the service have thorough understanding of the specific requirements of the service and that all standards are met.

This includes the following:-

- Professional registration
- DBS checks
- Appropriate skills and qualifications

- Mandatory training
- Training and development updates
- Making sure the clinical workforce is able to meet the needs of the patient

The provider will ensure that:

- Any transferring staff do so under Transfer Undertakings (Protection of Employment) (TUPE)
- Induction training for staff is in place
- HR policies are in place
- There is a staff appraisal system in place

Safeguarding:

- When appropriate the team will assess and make the relevant referral to social services if there are any concerns regarding safeguarding children, vulnerable adults, and other family members.
- Team members will contribute to the delivery of multi-agency safeguarding plans as appropriate
- Staffing structures must be in place to ensure induction of new staff and on-going case and clinical supervision of all staff. This must include safeguarding supervision from an appropriately qualified professional.

Safeguarding training

- The provider safeguarding team will ensure staff receive safeguarding training in accordance with statutory guidance "Safeguarding Children and Young People: roles and competences for healthcare staff (2014)" & "National Competence Framework for Safeguarding Adults endorsed by Learn to Care- Skilsforcare- Social Care Institute for Excellence (Galpin & Morrison: Bournemouth University (2010)"
- The provider must ensure the delivery of a comprehensive annual continuing professional development programme for all staff, ensuring within six months of joining:
    - Staff attend multi-agency safeguarding training at the appropriate level, for children and adults.

The Provider must comply with the standards below:

Applicable Local Standards

- Wirral Safeguarding Children's Board Policies and Procedures
- Wirral Safeguarding Adult Partnership Board Policies and Procedures
- Wirral Children's Partnership Council's Guide to Integrated Working (which includes comprehensive guidance on information sharing)
- Wirral MARAC policy and procedure
- Wirral Safeguarding Boards Standards for Safeguarding Children and Adults at risk Annual Audit Section 11 Children Act 2004/Chapter 14 Care Act 20014).

Applicable National Standards

- Working Together to Safeguard Children (DE/DH 2010/2013/2015)
- Children Act 1989 & 2004

- National Service Framework for Children, Young People and Maternity Services (DH 2004)
- Care Act 2014
- Mental Capacity Act & Deprivation of Liberty Safeguards (2005)
- NICE CG89: When to suspect child maltreatment (2009/2013)

3.8 Training / education / research activities

The service provider is to ensure that all staff providing this service, and linked referral pathways, have access to appropriate training (including mandatory), education, mentorship and research activities in order to improve their knowledge and expertise and keep abreast of developments within their area of expertise.

The service provider should consider an appropriate balance of staff in order to ensure the long term sustainability of the service.

The service will be an acknowledged source of expertise in the field of MSK, actively offering training and education to stakeholders and partners, and in the development of staff. This is to ensure, in the long term, expertise in the area of MSK increases on the Wirral, and that MSK services are sustainable.

Regular multi-disciplinary team meetings (MDTs) should be undertaken in order to consider complex and/or difficult cases. This is to ensure the best treatment pathways are identified for patients and also to promote teamwork and the sharing of knowledge and expertise across disciplines.

The service will deliver an education and training programme for GPs and health care professionals, along with providing advice and support relating to referrals, patient care, treatment, care post-discharge or shared care. A GP advice line should be in place five days a week, and any written requests should be responded to with 3 working days.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

This service will be provided in line with all the latest guidance and standards pertaining to MSK services. These include the following:-

- High Quality Care For All, DH, 2008
- The Musculoskeletal Service Framework - A joint responsibility: Doing it differently, DH, 2006
- Delivering Quality and Value – Focus on Musculoskeletal Interface Services, NHS Institute for Innovation and Improvement, 2009
- Delivering Quality and Value – Focus on Magnetic Resonance Imaging (MRI) and Low Back Pain, NHS Institute for Innovation and Improvement, 2008
- Delivering Care Closer to Home: Meeting the Challenge, DH, 2008

- Our Health, Our Care, Our Say – A New Direction for Community Services, DH, 2006
- NICE Guidance – Osteoarthritis: The Care and Management of Osteoarthritis in Adults, 2008
- NICE Guidance – Low Back Pain: Early Management of Persistent Non-Specific Low Back Pain, 2009
- Applicable National Service Frameworks (Long-term Conditions, Older People)
- Guidelines for GPs with a Special Interest (GPwSI): Musculoskeletal Conditions, RCGP, 2003
- The NHS Operating Framework for England, 2010/11, DH
- Care Quality Commission Core Standards
- NICE guidelines CG 66 Diabetes (update) May 2008
- NICE guidelines 2004 Prevention & management of foot problems in Type II diabetes
- Diabetes UK
- NSF for Diabetes
- NSF Standard 6 Falls November 2004
- NICE Guidance, Osteoarthritis: The Care and Management of Osteoarthritis in Adults, NICE 2014
- NICE Guidance, Rheumatoid Arthritis: The Management of Rheumatoid Arthritis in Adults, NICE 2009 & subsequent review
- NICE Guidance, procedure guidance on hips and knees
- National Service Frameworks, where applicable i.e. Older people
- Care Quality Commission – Essential Standards (specifically 16 Quality and Safety of Care Requirements)
- Health and Social Care Act 2012 and associated Regulations
- NHS England, Everyone Counts Planning for Patients 2014/15 to 2018/19
- HS Outcomes Framework 2014/15 (and any subsequent updates)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

- Arthritis and Musculoskeletal Alliance Standards of Care, ARMA, 2007
- The related Technical Appraisals and Interventional Procedure Guidance for Musculoskeletal/Rheumatological conditions.
- The Chartered Society of Physiotherapists – Core Standards and Service Standards, CSP, 2005

- Making the Best Use of a Department of Clinical Radiology, Guidelines for Doctors, 5th Edition, RC Radiologists, 2003
- Good Surgical Practice, Royal College of Surgeons, 2008 (and any subsequent updates)
- Guidelines for the provision of anaesthetic services, The Royal College of Anaesthetists 2014
- Implementation Manual Surgical Safety Checklist WHO 2009
- Codes of Professional Conduct – General Medical Council (GMC), Nursing and Midwifery Council (NMC) and Healthcare Professionals Council (HPC)
- Guidelines for the provision of Radiology services, The Royal College of Radiologists
- Guidelines for the provision of Surgeons, The Royal College of Surgeons

4.3 Applicable local standards

- Compliance with the Disability Discrimination Act, with appropriate impact assessments in place.
- Compliance with relevant Safeguarding Procedures
- Compliance with Wirral CCG's Procedures of Lower Clinical Priority (PLCP) policy

N.B The list of applicable service standards is not exhaustive and the provider is contractually obliged to review evidence on a continual basis,

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

A. Indicative Activity Plan

Insert text locally or state Not Applicable

Appendix 1 – Podiatry Service level Tiers

Tier 1 – **Core Podiatry - Low to Medium Levels of Foot Health Need** (instruments/consumables to be supplied by the Provider)

Service	Description
Treatment of Skin and Nail Conditions of the Foot: • Corns • Callus and hard skin • Verrucae • Thickened or ingrown nails • Fungal conditions of the feet and nails • Other dermatological conditions • Long Term conditions where the risk of foot ulceration and infection is low such as: o Low risk diabetes o Stable and low risk rheumatoid arthritis o Multiple sclerosis o Parkinson's disease o Connective tissue disorders o Oesteoarthritis • Structural and functional abnormalities • Patients requiring personal foot care (defined as toenail cutting and skin care) that are incapable of carrying out as part of their everyday personal hygiene.	To be responsible for the assessment, diagnosis, and treatment of patients with skin and nail conditions, including the provision of appropriate foot care education and health promotion.
Diabetes Management consistent with NICE Clinical Guideline 10: • To be responsible for the podiatric assessment, diagnosis and treatment of people with diabetes assessed as Low Current Risk, including the provision of foot care education (e.g. Patients who present with a chronic or acute condition that would benefit from Podiatry intervention. Such conditions may range from corn/callus reduction to in-growing toe nails to complex biomechanical abnormalities that give rise to joint and soft tissue pain). • Includes annual foot health check for patients referred to the service, who have not had an annual foot health check undertaken by General Practice within the last 15 months. To be provided as part of initial assessment to determine foot care required.	This will involve the examination of a patient's feet and lower legs to detect risk factors. Examination of patients' feet to include: • Testing of foot sensation using 10 g monofilament • Testing of vibration perception using 128mhz tuning fork • Palpation of foot pulses • Inspection for any foot deformity • Inspection of footwear Classify foot risk as: • Low current risk (normal sensation, palpable pulses, no significant foot deformity) • At increased risk (neuropathy or absent pulses or other risk factor) • At high risk (neuropathy or absent pulses plus deformity or skin changes or previous ulcer) • Ulcerated/infected foot

Service	Description
• A copy of all low risk diabetic foot checks must be sent to the patients' GP and referring clinician (if different) within a maximum of 5 working days. The patients' GP practice will then be expected to undertake annual foot checks from then on This will support the achievement of NSF targets in diabetes by identification of people with diabetes who may have not been picked up by primary care.	Foot care management plan to be agreed between the Podiatrist and the patient (taking into account patients' medical and surgical history, medication and ability to self-care) including education, as per NICE CG 10. Referral of At Increased Risk and High Risk patients to Tier 2 Specialist Podiatry Service Provider(s). Patients with foot care emergencies and foot ulcers should be referred to the Wirral University Hospital Trust Multi-Disciplinary Diabetic Foot Protection Team (Diabetes MDT) within 24 hours of being seen as per NICE CG 10 and local guidelines, any ulceration should be referred to secondary care. Treatment of patients assessed as low current risk may include: • Wound Care • Assessment of vascular and neurological disease status to help with treatment planning • Footwear advice and footwear referral • Provision of simple foot orthoses, basic insoles/chair side devices (i.e. cushioned insoles/memory foam liners, heel raise for leg length discrepancies) through to custom made foot orthoses (dependent upon symptoms) Foot health education to patients and carers
Rheumatoid Arthritis Management consistent with NICE Clinical Guideline 79: • To be responsible for the podiatric assessment, diagnosis, and treatment of people with rheumatoid arthritis assessed as Low Current Risk	Assessment and Management of foot problems associated with many rheumatological conditions. • Biomechanical assessment • Provision of simple basic insoles/chair side devices (i.e. poron/memory foam liners, heel raise for leg length discrepancies) through to custom made foot orthoses (dependent upon symptoms) • Assessment of vascular and neurological disease status to help with treatment planning • Footwear advice and referral to therapeutic footwear services • Onward referral to specialised team when tissue breakdown and/or acute episode or flare up e.g. o Diabetes MDT for ulcers (diabetic) o Vascular Surgical Unit for ulcers (non-diabetic)

Service	Description
	o For all other services, refer patient back to GP • Foot health education to patients and carers
Nail Surgery Procedures: • The treatment of nail pathologies such as in-growing toe nails, involuted nails and mycotic or thickened toe nails	The correction of nail pathologies with the use of local anaesthesia (LA) and minor surgical techniques which involves: • Taking a medical history to ensure that the patient is medically fit to have local anaesthesia • Removal of part or the whole of the nail that is causing the problem • The use of a chemical to obliterate the nail matrix (as appropriate) • Application of a post-operative dressing • Post-operative care, patient advice and follow-up as appropriate
Vascular and Neurological Assessments:	Vascular Assessment: • Palpation of foot pulses and use of Doppler to help with vascular assessment • Visual observations of the lower limb • Onward referral where appropriate Neurological Assessment: • Testing of foot sensation using 10 g monofilamentTesting of vibration perception using 128mhz tuning fork
Simple Wound Management (e.g. wounds not associated with diabetes, rheumatoid arthritis, peripheral vascular disease or any other long term condition)	This may involve: • Debridement of the wound • Use of appropriate wound dressing • Provision of simple foot orthoses, basic insoles where appropriate (i.e. cushioned insoles/memory foam liners) through to custom made foot orthoses (dependent upon symptoms) • Follow-up appointments or liaison with or referral to a specialised service (e.g. Tissue Viability Service or Tier 2 Podiatry) as appropriate • Referral of patients whose wound has failed to heal over time to a specialised service (e.g. Tissue Viability Service or Tier 2 Podiatry) as per local guidelines
Integral to the above is:	
Falls Prevention	• Assessment of footwear and recommendation of appropriate footwear

Service	Description
	• Provision of simple foot orthoses, basic insoles/chair side devices where appropriate (i.e. cushioned insoles/memory foam liners, heel raise for leg length discrepancies) through to custom made foot orthoses (dependent upon symptoms) • Education and information on how to reduce the risk of falling • Onward referral to other services i.e. Falls Prevention Team. Patients' GP and referring clinician should be informed of referral made
Foot Health Advice/Patient Education: • Low risk diabetic patients • General podiatric population	This may involve: • Patient advice and information as part of their care plan (including provision of leaflets or signposting to relevant websites for further information) • Promoting self-care to patients in order to ensure good foot health and mobility • Health promotion and education (i.e. smoking cessation and weight management) and signpost patients as appropriate

Tier 2 – Specialist Podiatry – High Levels of Foot Health Need (instruments/consumables to be supplied by the Provider)

Service	Description
Diabetes Management consistent with NICE Clinical Guideline 10: • To be responsible for the podiatric assessment, diagnosis and treatment of people with diabetes assessed as At Increased Risk and High Risk • A copy of all annual foot checks for 'At Risk' and 'High Risk' diabetic patients referred to the service must be sent to the patients' GP and referring clinician (if different) within a maximum of 5 working days. The provider will be expected to undertake annual foot checks for all 'At Risk' and 'High Risk' diabetic patients referred to the service on an annual basis	Treatment of patients assessed as At Increased Risk and High Risk may include: • Wound Care • Assessment of vascular and neurological disease status to help with treatment planning • Footwear advice and footwear referral • Provision of simple basic insoles/chair devices through to custom made foot orthoses (dependent upon symptoms) • Foot health education to patients and carers A tailored management/treatment plan to be agreed between the Podiatrist and the patient (taking into account patients' medical and surgical history, medication and ability to self-care) including education, as per NICE CG 10. All patients classified as At Increased Risk, should have a regular review arranged by the service provider(s) 3-6 monthly according to need as per NICE CG 10 or according to clinical need. All patients classified as High Risk, should have a regular review arranged by the service provider(s) 1-3 monthly according to need as per NICE CG 10 or according to clinical need. All people with diabetes should be recalled and reviewed as part of ongoing care, including those whose foot ulcer or lesion has resolved. Provide written and verbal education with emergency contact numbers. An essential part of the review of feet is patient education. Patients with foot care emergencies and foot ulcers should be referred to the Diabetes MDT within 24 hours of being seen as per NICE CG 10 and local guidelines (see Appendix 1 for Wirral referral pathways and local clinical guidelines. As per the University of Texas ulcer classification system (see Appendix 2), any ulceration should be referred to secondary care.
Rheumatoid Arthritis Management consistent with NICE Clinical Guideline 79:	Assessment and Management of foot problems associated with many rheumatological conditions. • Biomechanical assessment

Service	Description
To be responsible for the podiatric assessment, diagnosis and treatment of people with rheumatoid arthritis assessed as at risk rheumatoid foot as defined by: • Current use of TNF blockers, other biological disease modifying agents, or systemic immunosuppressant. • A history of more than five years of medication with oral steroid. • Current or recent vasculitis in the past 12 months. • A history of ulceration and/or skin infection related to their inflammatory disease.	• Provision of simple basic insoles/chair devices through to custom made foot orthoses (dependent upon symptoms) • Assessment of vascular and neurological disease status to help with treatment planning • Footwear advice and referral to therapeutic footwear services • Referral to specialised team when tissue breakdown and/or acute episode or flare up • Onward referral to other services as appropriate • Foot health education to patients and carers
Treatment of High Risk Foot (non-diabetes) such as: • Peripheral vascular disease • Systemic musculo-skeletal disorders • Immune mediated connective tissue disorders (including rheumatoid arthritis)	Assessment and treatment of people with conditions associated with high risk foot. Onward referral to other services as appropriate. Foot health education to patients and carers.
Specialist Wound Management	Management of foot ulceration (non-diabetic), where appropriate: • Use of appropriate wound dressing • Foot health education to patients and carers • Onward referral to secondary care or specialist services as appropriate Shared care follow-up approach to be delivered between secondary care and service provider(s) for the management of diabetic foot ulcers. Service provider(s) to assist with the delivery of agreed management plans, as directed by secondary care (e.g. wound dressings, monitoring).
Integral to the above is:	
Falls Prevention	• Assessment of footwear and recommendation of appropriate footwear • Provision of simple foot orthoses, basic insoles/chair side devices where appropriate (i.e. cushioned insoles/memory foam liners, heel raise for leg length discrepancies) • Education and information on how to reduce the risk of falling • Onward referral to other services i.e. Falls Prevention Team. Patients' GP and referring clinician should be informed of referral made

Service	Description
Foot Health Advice/Patient Education: • At increased risk and high risk diabetic patients • General podiatric population	This may involve: • Patient advice and information as part of their care plan (including provision of leaflets or signpost to relevant websites for further information) • Promoting self-care to patients in order to ensure good foot health and mobility • Health promotion and education (i.e. smoking cessation) and signpost patients as appropriate

Orthotics - Biomechanical Assessment, Advice and Provision of Foot Orthoses including advice/treatment of foot pain (instruments/consumables to be supplied by the Provider)

Service	Description
To provide an assessment, measurement, fitting and review service for patients identified as requiring foot orthoses (off-the-shelve insoles or custom-made insoles) To provide repeatable results for different footwear. To provide urgent appointments for diabetic patients, non-ulcerative (where clinically appropriate) to support the prevention and recurrence of diabetic foot ulcers. To repair custom-made foot orthoes in a responsive and effective manner. To provide a systematic re-assessment programme, with the frequency of reviews consistent with prognosis.	This may involve: • Anatomical and functional assessment of static and dynamic joint mobility • Assessment of soft tissue and muscle function • Strapping techniques • Vascular and Neurological assessment • Foot health education and footwear advice as part of a personalised care plan • Referral to the Wirral Community Appliance Service for footwear as required • Provision of simple foot orthoses, basic insoles/chair side devices (i.e. poron/memory foam liners, heel raise for leg length discrepancies) through to custom made foot orthoses (dependent upon symptoms) • Appropriate stretching programme

Appendix 2 – Pain Management Service Level Tiers

Tier 1 – Primary Care (For information only and is not part of the specification)
Primary care services – Patient primarily supported by GP.

First line advice and treatment consisting of:

• Assessment of pain symptoms and pain flare-ups and changes in physical function and / or emotional distress.

• Bio-psychosocial assessment.

• Encourage self-management through education and support including community pharmacists.

• Diagnostic tests including diagnostic imagining.

• Medicines optimisation for the patient

Referral to tier 2 services should occur where:

- the patient reports increasing pain intensity and distress +/ or worsening physical disability and deteriorating emotional role functioning.
- Patients whose pain persists for duration of greater than 3 months,
- Patients of less than 3 months where the GP may need additional support

Tier 2 – Community Pain Management Service (Integrated MSK Service)

The service will be based on a multi-disciplinary approach which may include medication management, physiotherapy, psychological support education and promoting self-management techniques.

A treatment plan (pain management plan) will be agreed in collaboration with the patient and any education and support delivered through a community based programme or signposting to self-help organisations.

The service will be provided as a minimum for 5 operational days (Monday – Friday between the hours of 9:00-17:30 excluding bank holidays) each week and provide the following:

• Daily triage.
• Daily 1:1 clinics including medication management and provision of Transcutaneous Electrical Nerve Stimulation (TENS) instruction/review where appropriate.
• Daily telephone clinics.
• Daily SOS appointment slots to meet patient need.

The service will also provide:
• Regular pain management education sessions to meet patient needs
• Multi-disciplinary team (MDT) meetings as required but on at least a monthly basis.

The key areas for which the Provider will have responsibility include:
• Integration of service provision at the acute/community interface, and to further develop services at this interface.
• Provision of a triage process providing assessment to patients within 3 operational days of receipt of referral for routine referrals and within 1 operational day for urgent referrals.
• Delivering evidence based pain management education for patients based on improving person centred outcomes specific to the individual.
• Support the discharge of patients from secondary care (criteria to be developed within one month after contract commencement).

- Promotion of the use of community based assessment tools.
- Sign posting to pain self-help organisations/groups and community based physical therapy
- Providing leadership and advisory support to Primary Care and community services (including GP's).

Secondary Care Tier 3 (Integrated MSK Service)

These treatments are hospital based and are aimed at patients with severe debilitating pain and patients for whom Tier 2 services are either not appropriate or the tier two service have agreed the need for onward referral. These will include:

- Identification of a patient who is failing to progress through the agreed pathway and an MDT discussion has taken place concluding that there is need for secondary care interventions/education;

- changes in presenting pathology that necessitates MDT discussion and onward referral;

- concerns based on clinical judgement by the Health Care Professional (HCP) managing the patient that requires MDT discussion and onward referral and

- referrals triaged with a suggested diagnosis of Complex Regional Pain Syndrome (CRPS) and facial pain with anorexia.

Tier 3 services may include onward referral to tertiary centres e.g. Walton, the provider will be responsible for referring patients to these services.

Appendix 3 – Domicillary Visit / Housebound Patient Criteria

Housebound patients criteria (applicable for all services provided by the MSK integrated Triage Service:

- Those who are so elderly and frail or infirm that it *prevents* them leaving the home
- Those with severe physical disability that *prevents* them leaving the home
- Those with certain mental health problems which make it *difficult to* leave the home
- Those with sensory disabilities especially severe visual impairment which makes it difficult to leave the home
- Those with profound or severe learning difficulties which makes it difficult to leave the home
- Those who are temporaily house bound e.g. post-surgery