SCHEDULE 2 – THE SERVICES

A. Service Specifications

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement
Optional headings 5-7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	1
Service	Musculoskeletal Service
Commissioner Lead	NHS Sheffield CCG
Provider Lead	Sheffield Teaching Hospitals NHS Foundation Trust
Period	1st September 2015 – 31st March 2020
Date of Review	Annual review March 2016

1. Population Needs

1.1 Population coverage all Sheffield Population registered with a Sheffield registered GP practice.

2. Outcomes

2.1 This contract is an Outcome Based Incentive Contract please See Schedule 4 part for further details.

3. Scope

3.1 Aims

The overarching aim of this Service is to provide a fully Integrated Musculoskeletal Service where Patients Outcome are the key measure for effective service delivery.

3.2 Service within Scope

The agreed speciality areas that are within scope for the MSK service are identified below.

Elective Orthopaedics including Critical Care, outpatient and unbundled high cost imaging activity.

- Hand surgery in Plastics excluding outpatient activity
- Elective Rheumatology including inpatient, outpatient and unbundled high cost imaging activity
- Elective Pain including inpatient, outpatient and unbundled high cost imaging activity
- Community Musculoskeletal Services
- Community Occupational Therapy
- Inpatient Physiotherapy
- Inpatient Orthotics

- Prescribing of Biologics (Anti TNF drugs)

For clarity the following are out of scope for the new MSK service:

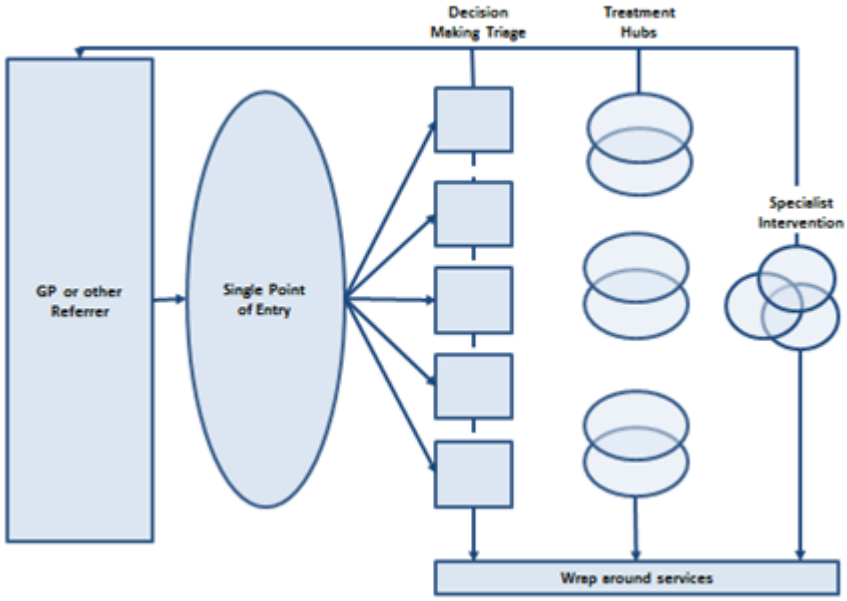
- All Non Elective activity for the above identified speciality areas
- GP direct access diagnostics
- GP direct access orthotics
- Primary care prescribing
- The local CCG commissioned DMARD service

The specific HRGs are embedded:

2015-16 - Schedule 2A - Service Specifica

3.3 Service description/care pathway

The primary focus of the agreed service model is to manage patients' needs at the lower levels of the model, with clear preventative programmes and early interventions, to reduce the volumes of patients who need more specialist intervention at the upper levels of the pyramid. Where patients have particularly complex needs, requiring specialist intervention, a guiding principle would be rapid access to specialists to enable rapid support. The following diagram summarises the agreed model for MSK care:



Features of the Sheffield MSK Managed Network

Prevention, Support and advice	**Core ethos/ principles/ standards** Self-management and health promotion will be at the heart of the model with empowered patients taking more responsibility for their own health. STHFT will provide a wealth of information and support to promote self-management, and to support the patient holistically when receiving care within the MSK model.

'Wraparound care'	**Features of the Model** - Web access support would be a key part of this. STHFT will work with patients to build on our existing good practice, extending and broadening the materials and information available at www.**sheffieldaches**and**pain**s.com. - Management videos, accessible via web, would be available, for patients within the service, or indeed on self-management topics - Access to patient support groups - GPs and other healthcare professionals will direct patients to resources from any place in the managed network of care - Development of close links with Sheffield services/ public health programmes that focus on health promotion – i.e. 'Move More', 'Weigh Ahead', 'Sheffield Occupational Health Advisory Service', 'National Centre for Sports and Exercise Medicine'. We would anticipate a broad programme of health promotion work, for the public generally.
Primary care assessment, and treatment	**Core ethos/ principles/ standards** GP's are pivotal to the integrated model of MSK care across the health economy. STHFT recognise that around 30% of GP workload relates to MSK and yet variable levels of confidence exist amongst GPs when treating MSK (Goodwin et al)[i]. Therefore support, referral guidance and a clear educational programme to enable early diagnosis and intervention, alongside supporting high quality onward referrals, is essential to the model of MSK delivery: 'In the future, general practice should play a pivotal role in the delivery of high-quality care to people with long-term conditions as part of a share care model in which responsibility is distributed across different teams' (Managing Patients with Long Term Conditions, Goodwin et al, 2010) **Features of the Model** - Clear entry criteria have been developed for the MSK model, with standard referral forms and minimum referral criteria in place. This would be rigorously implemented and monitored. - STHFT will develop a structure of 'linked GPs' working with a group of practices. These GPs will have specialist skills in MSK medicine, and would support the ongoing development of referral practice in GP practices. - There will be a clear body of evidence and evidence based guidelines on managing MSK pathways. These will be available to GPs, provided through a single web based tool. They will include Map of Medicine pathways such as support body pain, early pain, low back/radicular pain & stepped model of chronic pain management. - In addition, GPs will be supported through an educational programme, delivered by the 'linked' or 'Champion GPs'. The aim will be to up-skill these champions to increase their medical skills in the area of MSK, including expanding their ability to inject joints & improve diagnostic skills. They will also be crucial in supporting and up-skilling other GPs, , supporting the review of local audit data, providing feedback on referral practice to colleagues and in planning education strategies - The education programme will also develop 'expert patients', building on existing innovative practice in Rheumatology. - In addition STHFT will build on the excellent established clinical links with GPs and primary care professionals and will deliver a programme of educational sessions for GPs and other healthcare professionals, on MSK related topics delivered by the integrated

	specialist team. The service will utilise local audit data, including such information as most commonly sought telephone advice, and most commonly misdiagnosed conditions, to inform such training. Efforts will be made to liaise with practices to incorporate training and feedback into local programs of events, to ensure maximum take up - The educational programme would be supported and shaped by our MDT team within the MSK model, working in an integrated, cross-boundary way. Links & access to these specialists would be a critical part of the model - STHFT would anticipate GPs linking strongly with wraparound services, utilising the wealth of patient and healthcare professional materials available
Decision making triage and treatment hubs	**Core ethos/ principles/ standards** STHFT will integrate the existing community MSK service with specialist input within a single overall model of MSK care for Sheffield patients. Integrated, top quality care, with guaranteed input from specialist advice and rapid referral routes will be facilitated. This model will have a strong strategic and operational alliance with the Sports and Exercise Medicine Strategy. STHFT will expand and develop the current remit of the Community MSK Service enabling more patients to be managed in the community, therefore reducing costs associated with onward specialist referral. **Features of the Model** **Triage** - STHFT will undertake electronic triage within 1 working day of receipt of referral and will triage patients onto the most appropriate service for their needs. - The service will act as the single entry point for MSK referrals and specialists and GPs will work as part of an integrated team with physiotherapists and podiatrists to triage referrals and ensure the patient is directed to the most appropriate service. - The service will incorporate a broad range of community based pathways around specified standardised pathway approaches. - STHFT will operate a standard of rapid onward referral within an agreed standard for complex patients or 'red flag' patients who need rapid specialist input - **Development of Community Treatment Hubs** - Over the lifetime of the contract it is expected that treatment will be provided through a number of 'hubs' across the city. - Specialists are committed to the concept of community working, and the optimal location for these community hubs would consider the existing locations, and future options (including the National Sports and Exercise Centre developments at Concorde and Graves). The configuration will be mapped to areas of greatest MSK need. This will be a key area for discussion with our patient panel, and will be supported through high level analysis of MSK need, referral patterns and an understanding of deprivation across Sheffield, using the Sheffield Health and Wellbeing Atlas[ii]. - Community treatment hubs will be supported by the specialists, and there is commitment to working in the community from the specialist teams - A service will still remain on the hospital site, as for many people this is in the 'community' but more streamlined than currently –

	and offering a one-stop service (including on demand imaging and pre-visit bloods). - Subject to a robust business case, STHFT would aspire to deliver a specialist multidisciplinary 'shared service' MSK OP operating from common environment, with co-location of Orthopaedics, Pain services and Rheumatology with close links to other services with key clinical adjacencies such as psychological services. - It is anticipated that within these integrated treatment hubs multidisciplinary communication would be enhanced. The principles of MDT working in cancer have been discussed and will feed into our approach. It is anticipated seamless, efficient pathways would result with less potential for duplication and therefore fewer visits for patients. - In all our treatment hubs we would adopt a range of consultation methods, including email, phone consultation, face to face and remote monitoring. Expert advice would be accessible through a range of means, including patient videos. We would also anticipate a number of patient support groups, building on existing good practice. - Patients within the service would be able to contact directly for support and advice - STHFT see some links with potential emergency pathways, at the edges of this model, and would like to consider how the managed network could form effective partnerships with A&E to prevent A&E attendances and admission. - We would see the service working in close liaison with a number of key partners, which we have started to explore – including Sheffield Occupational Health Advisory Service, Health Champions, exercise management schemes etc. These partnerships are outlined in greater detail in section 9.
Specialised intervention	**Core ethos/ principles/ standards** At this stage, the core principles of our service would be to facilitate rapid surgical intervention or complex medical management plan when the patient meets agreed thresholds for treatment. **Features of the model** - The model will protect the needs of patients who require high cost drug regimes.. - STHFT will work to build on the existing enhanced recovery programmes to support recovery and discharge - STHFT will build strong pathways back to ongoing support in the community to support patient motivation & optimise outcomes - We anticipate high conversion rates from surgical OP reflecting patients - We would anticipate clinicians moving between the different stages of the service to ensure strong educational development and good integrated working - We need to ensure complex patients have rapid access to specialised interventions when they require it - Subject to the urgency of the patient, we would anticipate that many patients would be significantly 'worked up' by the Community Treatment Hubs before reaching the more specialised end of the treatment spectrum
Enablers for the MSK model – requiring joint commissioner/	The following to be key enablers to support the implementation of the overall model: • The implementation of Choose and Book across the health

provider work	economy to enable electronic transfer of referral information, which will aid streamlined pathways. As a general principle we wish to work towards paperless communication with CAB as the first step. • More generally, IT connectivity across our model and with primary care will be vital. Existing services variously use SystmOne or hospital based information systems. Better connectivity between these is crucial to aid communication and seamless care across our integrated model and with our referrers. • Agreement of PROMs that will commence at GP level and feed right through the MSK model at all levels. • Appropriate join up with commissioner performance frameworks that support primary care– this would help ensure compliance with the single point of entry to the MSK model, for example and compliance with primary care PROMs reporting • A programme of health promotion and prevention agreed across the health economy that supports and enhances the model of MSK care in the long term. • Good operational connection across commissioners and STHFT on key operational issues important to seamless care – i.e., transport arrangements etc.
Underpinning operating principles	• STHFT recognise the need to deliver Patient Choice within the model and also NHS Constitution pledges such as 18 weeks.