Delivering integrated community musculoskeletal services to the Oldham GP population
Contents

Part 1

1.1 Our Quality Account  
1.2 Board Statement  
1.3 Key Successes and Innovation Delivered in 2014/15

Part 2

2.1 Priorities for Improvement in 2014/15  
2.2 Priorities going forward 2015/16  
2.3 National Clinical Audit participation  
2.4 Core Service clinical audit programmes  
2.5 Research Statement  
2.6 Statements from the CQC  
2.7 Safeguarding Statement  
2.8 Data Quality  
2.9 Information Governance toolkit attainment  
2.10 Service Recognition  
2.11 Highlights of initiatives to improve service user experience and feedback

Part 3

3.1 Review of quality performance

Appendix 1: Glossary of terms
Part 1

1.1 Our Quality Account

This is the first Quality Account produced by Pennine MSK Partnership. The account is our public statement of our commitment to improving quality and safety in the service.

The purpose of our Quality Account is to demonstrate the Service’s commitment to improving quality and safety for the people who use our services. It presents:

Where improvements in quality are required

What we are doing well as an organisation

How service users, carers, staff and the wider community are engaged in working with us to improve the quality of care within the service.

1.2 Board Statement

All providers of NHS healthcare services are required to produce a Quality Account – an annual report to the public about the quality of services delivered.

We welcome this opportunity to take an honest look at how well we have performed during the reported year and to outline future improvements we aim to make.

We have worked with the following groups to produce our Quality Account:

- Clinical Governance Team
- Information Governance Board
- Staff, service users and carers from across the organisation
During 2014/15 the service was accredited for the fifth time with the Customer Service Excellence Award.

The Standard tests, in great depth, those areas that research has indicated are a priority for service users, with particular focus on delivery, timeliness, information, professionalism and staff attitude.

The assessment again evidenced full compliance with all measures.

The Rheumatology Nursing Team were finalists and eventual winners in the Community Nursing category in the RCN National Nursing Standard Nurse Awards.

Our Rheumatology Team were also finalists in the Nursing Times 2014 Awards in the Award for ‘Integrated Approaches to Care’.

We would like to congratulate the staff on their achievements and thank them for their continued dedication and excellent service provision.

These awards are just a few examples of the recognition we have gained during the last year.

Our aim is to maintain the momentum so that every patient experiences high quality, safe, personalised healthcare in an appropriate setting.
We can confirm that to the best of our knowledge the data and information in parts two and three of this report reflect both success and also areas for improvement going forward in 2015/16.

1.3 Key Successes and Innovation delivered in 2014/15

Patient Safety

All services have appointed safeguarding champions to promote support to the staff service teams.

User Experience

We continue to achieve a significantly high level of feedback both through patient surveys and through the friends and family feedback.

Quality Management Systems to Improve Capacity and support to staff

We have aligned Information Governance policies and procedures to ensure they are fit for all services and we implemented a mandatory IG training programme for all staff.

Virtual Consultant Clinics

We have introduced virtual consultant clinics in both Rheumatology and Orthopaedics to enable a speedy expert opinion for patients with potentially Serious or uncertain diagnoses.
Part 2

2.1 Priorities for Improvement in 2014/15

Our key objective is to keep the patient at the heart of everything that we do by providing outstanding care and support to every patient, every time.

Priority 1

Ensuring service quality, safety and enhanced user experience. Providing excellent clinical outcomes, and meeting and exceeding relevant standards and regulatory arrangements.

As part of our service quality improvements scheme we agreed to be a pathfinder site for the Friends and Family Test. This involved being an early implementer, ahead of the national implementation deadlines to measure the experience of patients in the hip and knee arthroplasty pathway. The pilot was to measure the experience of patients along end to end pathways in such a way to gain experience on transitions or handoffs between providers.

The above scheme was followed quickly by the full implementation of the Friends and Family test for all patients across all services with effect from October 2014.

We continued to roll out the use of patient decision aids in the use of the Collaborate tool. This was to support the shared decision making initiative by removing some of the perceived barriers for patients in ensuring they are as fully informed and able to contribute to the shared decision making process for any decisions that affect their care.

We have worked with partner organisations to finalise the re-designed clinical pathway for patients suffering from persistent pain. This is a major change to the current pathways and moves towards a bio psychosocial model of care attempting to de-medicalise treatments with an emphasis on self-care. This is totally new approach to care and offers patients a number of treatment options which are tailored to individual patient needs.

The pathway will enable psychological support to be accessed by all patients for whom it is deemed to be helpful.
Priority 2

Robust Governance: fostering safeguarding and quality assurance processes which are standardised across the service.

We agreed to a quality improvement scheme as a CQUIN to use a change improvement methodology to improve and sustain change in relation to a Lessons Learned Theme, identified and agreed from areas such as serious incidents, claims, complaints and serious case reviews. The rationale was to demonstrate improvement and to embed the culture of transparency, duty of candour and learning, in relation to patient safety.

The scheme helped to develop the methodology for audit and reporting of patient safety evidence to department level. A Joint Safety Collaborative meeting schedule was established with key principles against which evidence could be presented and reported against milestones with the identification of any issues. Trends were reported quarterly to the Medicines Governance Committee.

Priority 3

Continue to be recognised as an employer of choice

We introduced an e-learning mandatory training programme to allow greater flexibility for staff to be able access the training package from multiple locations and at a time to suit them.

We encourage and fund staff to attend national and local conferences and educational events to keep up to date with developments and to enable networking with professional colleagues.

We have introduced the role of Assistant Practitioner as an opportunity for our healthcare assistants to access additional training, skills and a further qualification.

We have developed and promoted the clinical peer review programme in providing funded clinical training for all clinical staff on a six weekly basis with multi-professional input and the opportunity to discuss complex or challenging cases with experts and colleagues.
We again hosted our annual staff away day for the whole team where a variety of activities were available to help promote and maintain the excellent relationships between members of our wider team.

To promote a healthy workforce we have introduced a supply of fruit baskets twice weekly to encourage staff to eat healthily. We fund 50% of gym/sports club annual memberships to encourage employees to partake in exercise and maintain an active lifestyle. We have also registered a cycle to work scheme and are planning to introduce complimentary Pilates classes.
2.2 Priorities going forward 2015/16

Priority 1

Ensuring service quality, safety and enhanced user experience. Providing excellent clinical outcomes, and meeting and exceeding relevant standards and regulatory arrangements.

We continue to conduct the Friends and Family test for all appointments in the service, using the feedback constructively to improve the service.

The new pain pathway has been introduced and will enable speedy and appropriate access to the pain professional most able to help the patients entering the service. We have incorporated a number of service outcome measures that will be reported to measure the impact of the various treatment options on the well-being of the patients.

Priority 2

Robust Governance: fostering safeguarding and quality assurance processes which are standardised across the service.

To extend the training for staff to include the challenges of working with patients with learning disabilities and to raise awareness of patients and families who may be subject to domestic abuse.

To continue to report on and examine the outcomes of the newly introduced methodology for reporting patient safety evidence.

To ensure that the outcome demonstrates improvements and continues to embed the culture of transparency, duty of candour and learning, in relation to patient safety.
Priority 3

**Continue to be recognised as an employer of choice**

To monitor and expand the e-learning concept wherever appropriate across the service.

To evaluate the progress of our first trainee Assistant Practitioner with a view to extending this training opportunity to other members of that staff group.

To continue to support the training and development opportunities of all staff groups to encourage staff to extend and enhance their skills and experience.

To carefully manage the training, support and integration of the newly appointed staff in the recently established pain team to ensure that the patient focussed objectives of the service are fully embedded into the new pathway.

---

2.3 National Clinical Audit participation NCAPOP

We are participating in the National early RA audit and two of our Directors are members of the Project Working Group. We are the top recruiting service in the North West having entered 122 patients into the audit.

The first Annual Report from the audit will be published in September 2015.

We intend to use the feedback from our annual report due in 2015 to explore any variation from standards that may occur and to make recommendations for service improvement where necessary.

---

2.4 Core Service clinical audit programmes

We maintain a rolling programme of audit activity aligned to local and national service priorities and support clinicians to produce annual audit aligned to pathways and service priorities and action plan that addresses any variation from standards.

The national RA audit as detailed in 2.3.

The local audits conducted in 2014/15 include;
To quantify the effectiveness and safety of the prescribing practice of an Advanced Practitioner Physiotherapist (APP) in enhancing the patient journey and adding value to the service.

To assess the appropriateness of referral for MSK ultrasound scans in measuring the requests against nationally accepted standards.

To confirm that, the facilities and procedures for the preparation of injectable medicines in clinical areas, are compliant with Acceptance Criteria.

2.5 Research Statement

We have embedded research and audit as standard components of patient care and have increased access to new treatments and evidence based care for our patients.

We test new and established approaches to care to ensure the provision of best practice:

We tested Option grids for OA knee in collaboration with Cardiff University supported by a grant from the Bupa Foundation. We fed back the study findings at Clinical Peer Review in May 2015 and have recommended the use of the Option Grid for OA knee based upon an increase in decision quality; greater awareness of risks and benefits and qualitative data which showed that the use of the grid was positively received by both patients and clinicians.

In July 2014 we opened recruitment to the Instincts study: A randomised, multicentre, clinical, open label, parallel group pragmatic trial of local steroid injection versus night splinting in patients with mild to moderate carpal tunnel syndrome. We are the top recruiting centre in the UK having screened 136 patients, 73 of whom were eligible and 22 have been recruited to the study.

Two of our clinicians were co-applicants on a successful Research for Patient Benefit (RfPB) application to evaluate the effectiveness of compression gloves in arthritis (P.I. Professor Alison Hammond, University of Salford). This is a multi-centre Phase III randomised controlled trial of Isotoner compression gloves compared to placebo (slightly loose fitting Norco oedema) gloves in people with RA or Early Inflammatory Arthritis (EIA). Randomisation will be stratified by whether participants recently started or changed Disease-
Modifying Anti-Rheumatic Drugs (DMARD) or biologic drug (as this can affect hand symptoms) or not. Participants will be assessed at baseline and 2 months, the latter by postal questionnaire.

Oldham CCG have agreed to fund the Health Foundation application ‘Innovating for Improvement Musculoskeletal triage service for children and young people – ‘getting the right child to the right place at the right time’ (PI Helen Foster, Newcastle University; co-applicant AN). Stakeholder consultation events have been held in Oldham and Newcastle and draft paediatric referral criteria have been developed.

We host and recruit to time and target for industry sponsored trials of investigational medicinal products:

We are currently hosting the Act-Move open-label, Phase IIIb clinical trial study to evaluate the efficacy and safety of subcutaneous tocilizumab monotherapy or combination therapy with methotrexate or other non-biologic DMARDs in patients with severe RA.

We are horizon scanning for new opportunities through engagement with Clinical Local Research networks, pharmaceutical companies, daily NICE awareness alerts and national contacts and engagement with national organisations.

2.6 Statements from the CQC

Our services are required to register with the Care Quality Commission (CQC) and we have no conditions attached to our registration.

Our services have not participated in any special reviews or investigations by the CQC in the reporting period.

There were no service inspections conducted by the CQC during 2014/15.

At the last inspection in August 2013 the service was deemed to be fully compliant with no improvement action plan.
2.7 Safeguarding Statement

We are committed to safeguarding and promoting the welfare of adults, children and young people and to protect them from the risks of harm.

The service has in place safeguarding guidance and practices in line with statutory and national requirements.

Our Clinical Governance and Safeguarding Committees provide board assurance that our services meet statutory requirements.

Named professionals are clear about their roles and have sufficient time and support to undertake them.

Safeguarding policies and systems for children and vulnerable adults are up to date and robust. All appropriate staff have undertaken and are up to date with safeguarding training at Level 1 and 2A.

This is included in induction and integral to the organisations mandatory training policy.

Pennine MSK Partnership Limited are committed to adhering to the Department of Health Prevent strategy and are working to ensure that all staff understand the Prevent strategy and where there are signs that someone is being drawn into terrorism, those signs can be interpreted correctly and staff are aware of the support that is available and are confident in referring the person for further support.

2.8 Data Quality

Pennine MSK Partnership Ltd submitted information during 2014/15 to the Secondary Users Service (SUS) for inclusion in the Hospital Episodes Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient’s valid NHS number was 100%

The percentage of records in the published data which included the patient’s valid General Practitioner Registration code was 100%

Local Initiatives to improve data quality:
Read code training provided to all administrative staff.

Extensive coding templates designed and implemented to ease the process for clinicians in clinic settings to improve the accuracy of outcome and activity data.

2.9 Information Governance (IG) toolkit attainments

An IG Board has been established as we were required to use the IG toolkit during 2014/15.

In working towards our compliance we have commissioned specialist input to assist us with the identification of the evidence, the policies and procedures and any changes to practice that may be required to achieve compliance with the toolkit.

On completion of this programme of work, full compliance to Level 2 will be achieved.
2.10 Service Recognition

The rheumatology nursing team were finalists and eventual winners in the Community Nursing category in the National Nursing Standard Nurse Awards.

Dr Alan Nye, a Director of the service was named as one of the HSJ Top 50 Innovators in Healthcare. The HSJ statement included the following:

“Long before CCGs came along, musculoskeletal patients in Oldham were benefiting from a clinician-led organisation. The partnership has overcome challenges with vision, perseverance and strong leadership skills as well as nous and pragmatism to establish what has become a ground breaking service.”

The service was also a finalist in the Nursing Times Award in the category for Integrated Approaches to care.

The service was used as a case study in the NHS Confederation Community Health Forum in exploring how outcome based commissioning can help unlock the potential of community services.

Figure 2: Sarah Critchley, Rheumatology Specialist Nurse (Centre), accepting the award for Community Nursing 2015 at the RCN Nursing Standard Nurse Awards in London.
2.11 Highlights of initiatives to improve service user experience and feedback

We continued to work on the inspection criteria that allow us to apply for re-accreditation under the Customer Service Excellence Scheme.

This standard which was developed by the Cabinet Office to deliver the government initiatives services for all that are efficient, effective, excellent, equitable and empowering with, in our case , the patient always and everywhere at the heart of service provision.
3.1 Review of quality performance

We pride ourselves in offering an excellent experience for all our patients.

At a local and national level we have led the implementation of shared decision making, striving to ensure that all our patients are fully involved in any decision about their care. This is measured using the CollaboRATE score. CollaboRATE measures the level of shared decision making in the clinical encounter from the patient's perspective using a brief patient reported measure of shared decision making that is highly accessible to users.

Our main Key Performance Indicators and our achievements against them are provided;

- **Referral to Treatment (RTT)** - We have a target to treat 95% of patients within 18 weeks from referral. We averaged 99.7% during 2014/15
- **Diagnostic Waiting Times** - We are challenged with ensuring that patients wait less than 6 weeks from referral for a diagnostic test. We achieved this in 100% of patients.
- **Did not Attend (DNA)** - We have targets to achieve rates of no higher than 9% and 9.5% of patients who miss their first or follow-up appointment. We averaged 5.4% and 7.4% respectively.
Patient Satisfaction

This is measured using a combination of Patient Surveys and the Friends & Family Test (FFT). In the surveys, conducted throughout the year, 94% of patients were either satisfied or completely satisfied with the service.

The FFT has been rolled out to all patients during the year. For this we use a text and Interactive Voice Messaging facility that contacts all patients (who have provided us with a contact number) following their first appointment asking them to complete the FFT.

This test asks patients to rate the service on a scale from 1 to 6 with regard to whether they would recommend our service to their friends and family:

“How likely are you to recommend Pennine MSK Partnership to friends and family if they needed care or treatment?”

To date our average score for this test is **95% positive** meaning that 95% of patients who completed the Friends and Family Test scored ‘extremely likely’ or ‘likely’ to this question.

This facility also allows patients to text us or record a voice message with their follow up comments explaining why they gave the score they did. This has provided us with invaluable, real time patient feedback, examples of comments we receive can be found below:

“I have always received excellent treatment at MSK. The people there are very understanding and treat you with respect. They cannot do enough for you and are only a phone call away if needed between appointments."

“My clinician was professional and well mannered. He was very positive about my back and in turn gave me new hope that I will have a pain free life once again."

“The lady I saw was lovely kind and very good at her job, the service delivered was the best I’ve ever had!”

“The care I received was excellent, my appointment was on time and the healthcare professional was efficient and sympathetic. In all, I’m very happy with my experience at MSK!”
Appendix 1

Glossary of Terms

Virtual Consultant Clinics - These are scheduled clinics where a consultant’s time is secured, to review the records of patients for whom clinical colleagues would value a consultant opinion. It allows the opportunity for the consultant to speak directly to their clinical colleague and to enable the patient journey to be effected in the most efficient way.

Care Quality Commission

The Care Quality Commission (CQC) replaced the Healthcare Commission, Mental Health Act Commission and the Commission for Social Care Inspection in April 2009. The CQC is the independent regulator of health and social care in England. It regulates health and adult social care services whether provided by the NHS, local authorities, private companies or voluntary organisations.

Clinical Audit

Clinical audit is a process that has been defined as a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implications of change.

Commissioning for Quality and Innovation (CQUIN)

The CQUIN payment framework enables commissioner to reward excellence by linking a proportion of Healthcare providers’ income to the achievement of a combination of local and national quality improvement goals.