

WELSH HEALTH CIRCULAR



Llywodraeth Cymru
Welsh Government

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Title: Clinical Musculoskeletal assessment Treatment Service (CMATS)

The Welsh Orthopaedic Board has developed a Clinical Musculoskeletal assessment Treatment Service principle document.

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For Action by:

*Local health boards
NHS trusts*

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Enclosure(s):

Clinical Musculoskeletal assessment Treatment Service (CMATS) document



12 September 2017

In December 2013 the Minister for Health and Social Services announced his intention to establish a Planned Care National Work Programme for NHS Wales.

“Our planned care system is also facing challenges. Some of these are a consequence of the pressure in our unscheduled care system. However, others relate to working practices and delivery arrangements. Whilst there are many areas of strength, there are others which now need to be modernised. There is a need for significant and urgent change I have therefore decided to replicate the model introduced last year for Unscheduled Care through a National Planned Care Programme”

In July 2015 a Welsh Orthopaedic Board was established to address the action needed to ensure the development of a sustainable service. Orthopaedics is the biggest single planned care service in Wales, where demand for treatment is increasing significantly for reasons including: ageing population, growing levels of obesity and advancements in clinical practice which has led to unacceptably long waits.

The Welsh Orthopaedic Board has agreed an integrated (primary and secondary care) approach to providing an Musculoskeletal assessment service as a first point of contact for General practitioner and emergency department referrals for the assessment and treatment of Musculoskeletal related pain outlined.

National principles have agreed to ensure referrals for Musculoskeletal conditions within the agreed parameters are streamed directly to the appropriate specialist service, offering patients faster access to assessment and treatment.

Regards

Dougie Russell
Chairman
Welsh Orthopaedic Board

Peter Lewis
Clinical Lead
Planned Care Programme

Recommended Guidelines

Establishment of a Clinical Musculoskeletal Assessment Treatment Service

Overview

Welsh health boards should operate a referral, assessment and treatment service for all soft tissue and joint conditions that are non-inflammatory and do not require emergency treatment. This should be the default service and first point of contact for all General Practitioners (GP's), Consultant, Allied Health Professional (AHP), Accident & Emergency (A&E) referrals for assessment and treatment of musculoskeletal (MSK) related pain and conditions that are not rheumatological, urgent suspected cancer or emergency cases.

This service will be an integrated and targeted approach combining primary and secondary assessment, intervention and treatment. It will not be a standalone service and will form part of a spectrum of musculoskeletal service and is fully integrated across primary care, mainstream therapy services and secondary care orthopaedic and rheumatology led services. The care given will be in line with agreed pathways between primary and secondary care, and the service will maintain close relationships between it, GP's and orthopaedic surgeons.

The service will need to include weight management approaches and smoking cessation guidance. It will assist in the reduction of dependency to manage MSK problems, supporting individuals to adopt lifestyle changes, offering prudent healthcare and co-production prior to surgery.

Where possible the service will recognise the value of the third sector to support self management of patients.

Aim

To provide a community based service for the assessment and treatment of MSK-related pain and MSK conditions

It will do this by:

- Simplifying the MSK referral pathway, reduce duplication, prevent multiple referrals and re-referrals and create a sustainable solution whilst ensuring appropriate and timely access to MSK services.
- Accepting referrals, organising diagnostic investigation and initial management and refer onward where appropriate.
- Establishing a single point of access: 'one-stop shop' principles should be adopted where possible, with appropriate radiological imaging being organised at the right point of the pathway.

Objectives

Deliver a high quality, sustainable and safe service, based on prudent healthcare principles, at the primary / community / secondary care interface point of the MSK pathway to:

- Improve patient access to MSK services appropriate to the patient's level of need.
- Provide the patient with the necessary education and information to make informed choices, self-management and possible surgical options.
- Ensure patients are seen and treated in an environment most suited to their needs and as appropriately close to home as possible.
- All GP referrals must be made direct to CMATS, referring GP's will retain the right to give their opinion of the urgency of the case and whether they feel that a referral to orthopaedic is the likely outcome, however a final decision would be made at triage within the CMATS' based on the information received from the referring clinician and in agreement with local guidelines/pathways. Consideration should be given to national guidelines for what constitutes an urgent or a routine referral and education will be provided to referrers.
- Signpost the patient to appropriate local authority/community information and lifestyle advice to support ongoing and future self management. Enhance good quality management of MSK services in primary care for cases where effective interdisciplinary working will improve outcomes.
- Improve and optimise access to secondary care services.
- Provide best value for money in the management of MSK services across the care pathway whilst achieving good outcomes for patients.
- Optimise number of appropriate referrals for pain, rheumatology and orthopaedic conditions to specialist secondary care services
- Optimise conversion rates from trauma and orthopaedic out-patient attendance to surgery.
- Manage and deliver MSK services in accordance with the most recent evidence base.

Core Principles

- All referrals should go directly into the service for triage within 5 working days (referrals should be made using Welsh Patient Referral System (WPRS) in line with health board plans for implementation).

This would not include GP-initiated or self referrals to physiotherapy out-patient departments (OPD) for a course of treatment.

Outpatient clinicians will be able to refer any patient to CMATS, they feel may benefit from a further opinion from the CMATS team following their assessment.

The CMATS lead needs to be clearly defined and agreed by each health board, and, as a minimum the service should be led by a skilled clinician

with postgraduate experience/qualification in the management of MSK conditions as well as leadership skills to head up this service. Ideally a Consultant in Sports and Exercise Medicine would be part of the leadership team.

The lead clinician must have a proven MSK professional body level of experience and skills suited to the variable MSK demands of the role. This may be a shared role between health professionals, dependant on the needs of the service, and the population of the health board, to provide a strong and well rounded level of leadership to the service.

The lead clinician will be responsible for all quality, safety and patient experience aspects of the CMATS, and close working relationships with secondary care services, including joint Continuous Professional Development (CPD) and audit.

- The service should not work in isolation and requires a commitment of all staff to work integrated with others across the MSK pathways to ensure delivery of holistic patient centred care, streamlined provision and avoidance of duplication.
- CMATS should not be seen as an extra tier or referral management. If necessary, the service can refer onward to secondary care services as required.
- CMATS will have direct access to diagnostics within 6 weeks and secondary care specialist advice if appropriate. The latter may be via e advice, discussion at multidisciplinary team meeting or referral (via WPRS in line with health board plans for implementation).
- Encourage and support individuals through co-production, to adopt lifestyle management with self-care and learn to manage their own symptoms long term.
- Ensure patients have appropriate advice and support to enhance shared decision making about their future treatments and care
- Education, Personal and Development Reviews (PADR), CPD and appraisal monitoring systems in place to promote use of best practice.

It is intended that all MSK referrals will go into the service, apart from the exclusions set out below and referrals to physiotherapy OPD.

Patients will be assessed in clinic by suitably qualified CMATS staff and where appropriate, referred for diagnostics in accordance with guidelines and agreed care pathways.

- Patient outcomes will be agreed nationally and delivered locally through agreed patient reported outcome and experience measures. Other outcomes that will need to be developed within the service include regular

audit of outcomes of referrals to secondary care, evaluation of re-referrals to the service, audit of injections provided and appropriateness of radiology requests.

Regular bi-monthly review days for audit, education and review of significant events and complaints should be mandatory.

Inclusion Criteria

The following criteria must all be met for referral to CMATS

- All primary care referrals for orthopaedics
- Registered with a local health board or GP
- Aged 16 and over
- All paediatric referrals will go directly a to paediatric orthopaedic service. This may vary locally as agreed between the lead clinician and secondary care consultants.
- Presents to GP, NHS physiotherapy, podiatry OPD, and / or A&E or other NHS clinicians with pain, or MSK condition not identified in 'exclusion criteria'.
- All conservative measures are exhausted prior to consideration of referral.

Exclusions

CMATS should NOT be the referral option in cases with the following presentations.

At triage these cases should be appropriately signposted if that is possible based on the information received from the referrer:

- Suspected new or recurrent cancer – use “Urgent Suspected Cancer” pathway.
- Require emergency treatment
- ‘Red flag’ symptoms including suspected cauda equina syndrome, suspected acute rheumatologic pathology
- Widespread neurological symptoms

Target Times

Referral into CMATS will NOT initially be included as part of RTT. This will be reviewed and reassessed in 12 months from implementing and therefore the following milestones are suggested:

For the first 12 months of roll out the following referral times will be applicable:

Receipt of the referral into the service to a decision to treat or either discharge or appointment with clinician or other service –6 weeks.

Performance Indicators

In order to assess the impact of the CMATS across Wales, health boards will be expected to report upon the following measures as part of the orthopaedic monitoring return.

The measures can be used for benchmarking across Wales and for internal health board management of the service.

CMATS Metrics

Metric to be reported quarterly	Description
Total wait	Total number of patients on a CMATS list awaiting a first appointment.
Total wait > 6 weeks	Total number of patients on a CMATS list waiting more than 6 weeks.
Total NP seen	Total NP CMATS contacts. This includes first contact face to face and telephone assessments.
Total FU seen	Total FU CMATS contacts.
NP DNA	Percentage of new patients that DNA.
Discharge outcome from CMATS contact	Percentage of patients referred to each discharge pathway from each CMATS episode of care. Examples of discharge pathways include core MSK, core podiatry, ortho, pain, GP, oncology, etc..
Total steroid injections performed	Total number of intra or peri-articular injections performed by the service.
Referrals to radiology:- <ul style="list-style-type: none"> • X-ray • MRI • Ultrasound • Nerve conduction studies • CT 	Percentage of referrals to radiology for each differing investigation should be reported (Eg: X ray, MRI, ultrasound, nerve conduction studies, CT). This should be considered in terms of each episode of care. To calculate:- Use the Total number of new patient referrals booked for clinical assessment and the number of investigations ordered (Eg: X ray, MRI, Ultrasound, CT).

Metric to be reported annually	Description
Total Referrals received to initial triage	Total Referrals received to initial triage. Organisations should work towards full compliance with electronic referral.
Initial triage pathway selection	This is inclusive of all paper / electronic referrals to CMATS. The percentage of referrals triaged to each pathway from the total received is required. (This includes all appropriate specialties Eg: CMATS, ortho, pain, rheum, CMATS, NERS, physio, podiatry etc..). *
Referrals triaged within 5 days	The percentage of all referrals (paper or electronic) triaged within 5 days.

*At the time of writing this guidance many organisations cannot currently fully comply with this metric as electronic systems are not in place to monitor. Manual data collection is not pragmatic. All organisations should work towards full compliance with electronic referral management systems.

Other metrics to support annual service performance monitoring:-

- Conversion rates for patients seen in CMAT and referred to orthopaedics is considered to be an important metric. However at the time of writing this guidance document, IT infrastructure and systems are not sophisticated enough in all organisations to accurately report this data. As a minimum, snap shot manual audit of conversion rates is required in the short term. In the medium and long term solutions are required to allow full and robust reporting of this metric.
- Services should utilise PREM's and PROM's in order to evaluate quality outcomes. This should relate to specific interventions such as injection therapy as well as the impact of clinical advice relating to factors such as diagnosis, prognosis, expectation, condition management/ and exercise. At the time of writing this paper there is no consensus on which is the preferred measure. In the short term an evidence based approach should be used by individual services in outcome selection. In the medium and long term, national agreement is required.