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

The terms of this specification are formally notified as a Prior Approval Scheme. As set out within the NHS Standard Contract if the provider does not comply with the terms of a Prior Approval Scheme, the commissioners will not be liable to pay for the service provided. Any onward referrals to other specialties or departments within the Trust which are not in accordance with the specification will not be funded.
This approach is being applied consistently by the commissioners to their other contracted providers, including Independent Sector providers, who must only accept referrals to Trauma and Orthopaedics through this Integrated MSK service

Service Specification No.	
Service	Joint Health – Integrated MSK Service
Commissioner Lead	Terry Hill, Southport and Formby CCG Amanda Gordon, West Lancashire CCG Jan Leonard, Southport and Formby CCG
Provider Lead	Jan Wilson, Southport and Ormskirk NHS Hospital Trust
Period	April 2016- March 2019
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

In 2006, the Department of Health released "The Musculoskeletal Services Framework" which sets out evidence of best practice and recommends actions for change to improve musculoskeletal (MSK) services nationally. The vision of the MSK Services Framework is to fully utilise the skills and expertise of clinicians appropriately, to improve patient outcomes through a more actively managed patient pathway.

Musculoskeletal disorders (MSDs) have consistently been the most commonly reported type of work-related illness since records began. In the latest figures recorded in 2013/14 an estimated 526,000 people in Great Britain (GB), who had worked in the last year, believed they were suffering from a MSD that was caused or made worse by their current or past work. An estimated 8.3 million working days (full day equivalent) were lost through MSDs in GB in 2013/14. Within the NHS, half of sickness absence is caused by MSDs.

Demand for MSK services is high and has increased over the decade, particularly in the last 3 years: nationally, MSK conditions generally comprise around 30 per cent of all primary care consultations. Arthritis Research UK estimates that there are approximately 10 million people living with long term MSK pain in the UK.

1.1.1 NHS Southport and Formby CCG

In September 2014, Southport and Formby CCG signalled in its Commissioning Intentions that they intended to undertake a full review of the existing MSK Clinical Assessment Service (MCAS) and orthopaedic pathways. The main aim is to ensure that right care is

delivered for patients in the right place and improve quality of services for patients through ensuring value for money. The CCG has been looking at benchmark data identified in Commissioning for Value Packs (compared to their peers), validating the data, in order to understand where spend varies from the norm and where we can achieve better value for money. This indicates that there is still over-hospitalisation of patients in Southport and Formby; particularly in inpatient areas such as MSK services and procedures of limited clinical value. We have also seen increasing levels of referrals to providers outside of Southport and Ormskirk NHS Hospital Trust, namely Wrightington, Wigan and Leigh and Ramsay Health.

The prevalence of MSK conditions generally rises with age. Nationally, over the next 5 years it is anticipated that the local population will increase by 0.4% to 111,400; it is expected that the percentage of people over 65 will increase by 8.8% and the percentage of people over 85 will increase by 28.6%. Southport and Formby CCG however are already 20 years ahead of the national trend with a 1.4% increase in population by 2020 and 5.7% in those aged over 65 years of age. It is expected that by the year 2020, 27% of SFCCG patients will be over 65 years of age (National forecast at 23% by 2035). The CCGs needs to ensure that they are able to meet the needs of complex patients and support improve quality of life in the later years.

NHS Southport and Formby Clinical Commissioning Group (CCG) have a current population of approximately 115,596 (March 2016). The Health and Safety Executive report 'Musculoskeletal Disorders in Great Britain 2013' reported that the prevalence of work related musculoskeletal disorders in Great Britain is 1,480 per 100,000. The incidence is 500 per 100,000. This means that within Southport and Formby CCG the prevalence of work related MSK conditions is approximately 1,711 and the incidence is approximately 578.

1.1.2 NHS West Lancashire CCG

MSK services are identified in NHS West Lancashire CCG Strategic Plan 2015/16. The main aim is to ensure that right care is delivered for patients in the right place and improve quality of services for patients through ensuring value for money. The CCG has been looking at benchmark data identified in Commissioning for Value Packs (compared to their peers) validating the data in order to understand where spend varies from the norm and where we can achieve better value for money. This indicates that there is still over-hospitalisation of patients in West Lancashire; particularly in inpatient areas such as MSK services and procedures of limited clinical value.

In 2014/15 the cost of orthopaedic activity for NHS West Lancashire CCG was more than £2 million higher than expected from the national benchmark information. We have also seen increasing levels of referrals to providers outside of Southport and Ormskirk NHS Hospital Trust, namely Wrightington, Wigan and Leigh and Ramsay Health.

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NHS West Lancashire Clinical Commissioning Group (CCG) has a weighted population of approximately 119,000 (July 2015). The Health and Safety Executive report 'Musculoskeletal Disorders in Great Britain 2013' reported that the prevalence of work related musculoskeletal disorders in Great Britain is 1,480 per 100,000. The incidence is 500 per 100,000.

1.1.3 Commissioning Strategy

NHS Southport and Formby CCG in partnership with NHS West Lancashire CCG have begun the implementation of 'Facing the Future Together' as set out in 'Building for the Future; A Clinical Commissioning Strategy to support the delivery of Integrated Services'. Building for the Future is a reconfiguration that requires a fundamental change in the way

both acute and community services are delivered with a focus on delivering care as close to patients' homes as is possible.

In Southport & Formby and West Lancashire CCG's Commissioning Intentions in September 2014 and 2015, the CCGs signalled that they intended to undertake a full review of the existing MSK Clinical Assessment Service (MCAS) and orthopaedic pathways, and would consider re-commissioning this activity in a different way in 2016/17. The CCGs have adopted the principles of solution focussed shared decision making (SFSDM) to inform the shape of the new service and to introduce patient self-referral for routine physiotherapy.

The evidence base considered includes:

- The Musculoskeletal Services framework (DH 2006).
- NICE Guidance [CG177], Osteoarthritis. The Care & Management of Osteoarthritis in Adults (Feb 2014).
- NICE Guidance, Rheumatoid Arthritis. The Management of Rheumatoid Arthritis in Adults (Feb 2009).
- National Service Frameworks where applicable (Long Term Conditions, Older People)
- Healthcare Commission – Core Standards
- Healthcare Profession Council Standards
- The Chartered Society of Physiotherapy – Core Standards and Service Standards
- Patient experience in adult NHS services' (NICE clinical guidance 138)

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**X**
Domain 2	**Enhancing quality of life for people with long-term conditions** The service will ensure a higher proportion of people feel supported and educated to manage their MSK condition through patient education classes, Expert Patients, high quality web portal, best practice IOS and Android applications. Service users will be supported to return to work (for those not in work - maximise function and activities of daily living).	

	Domain 3	**Helping people to recover from episodes of ill-health or following injury** Joint Health Service will provide the elective care service for those patients that have attended an urgent care service (that would either be redirected back to the GP or put into an outpatient orthopaedic clinic) with back pain and/or soft tissue injury.	
	Domain 4	**Ensuring people have a positive experience of care** The service will use Solution Focused Shared Decision Making (SFSDM) in order to - provide more cheerful and motivational appointments; discuss informed approaches to diagnosis & management planning; help patients make good choices about their management plans and enable concordance based on what's important to them.	
	Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm** The chances of MSK complications developing can be significantly reduced by good MSK care, including attending to risk factors and timely referral and intervention, thus protecting from avoidable harm. In addition, the provider must ensure that all staff delivering the service are competent to do so. The specification sets out the policies that a provider is expected to have in place and ensure that these policies are used within the delivery of the service. The CCGs also require the service provider(s) to use a suitable integrated IT system, such as EMIS Community Web to deliver the service. These address the indicators that patient safety incidents are reported – they are reported on the system that clinicians have access to and that there is a reduction in incidence of avoidable harm – the service is delivered by trained staff with the appropriate policies e.g., infection control in place.	

2.2 Local defined outcomes

The service must act in the best interests of the CCG to contain Orthopaedic activity to specified national benchmark levels.

The service is to develop the facility to offer patients; live online chat during all service opening times, telephone assessment, and individual face to face appointments or group sessions as appropriate.

Where onward referral to hospital based care is required, the Service will be required to provide:

- Evidence that the service is developing and maintaining relationships and partnerships with all appropriate NHS and private Orthopaedic providers and promoting independent choice which will be monitored through Market share analysis;
- A consistent application of the thresholds for surgery; ensuring that potential referrals to secondary care are reviewed by a virtual MDT meeting led by an appropriately experienced Clinical Lead within one working week. Following this

peer review process, the service is to contact the patient at a pre-arranged time to discuss the outcomes and arrange appropriate advice and guidance/ referrals/signposting (referring on to be offered independent choice of secondary care provider where appropriate, via locally agreed process).

2.2.1 Quality Schedule

In order to address potential areas of conflict:

- The service will report to a joint Southport & Formby and West Lancashire CCGs MSK Programme Board which will initially meet on a weekly basis to monitor activity, spend on orthopaedics and performance against the KPI's within the contract. The frequency of the meetings will be reviewed as required.

- The Joint Health Service must receive explicit sign off from the CCG that the service level agreement between the service and its diagnostic provider(s) sub-contractors confirm that they have the capacity and capability to meet the non-negotiable service standards required.

- The service must have a suitably qualified and experienced Clinical lead that is appointment in agreement with the CCGs.

3. Scope

3.1 Aims and objectives of service

The overarching aim will be to deliver a MSK clinically-led community MSK service enabling all service users, who meet the criteria (as set out in Section 3.2.1) to be managed within the capability of the service. It aims to do this by ensuring service users/health professionals have access to a service that has all necessary skills, interventions and equipment to manage service users.

It aims and objectives are to ensure:

- Service users receive timely access to interventions (if necessary);
- Any health professional referring into the service has confidence that their patients will receive timely, clinically credible and high quality treatments;
- Service users receive high satisfaction from accessing MSK services that deliver the health improvements they are looking for;
- Diagnostic services to be commissioned by the service from which ever diagnostic provider (location within service catchment boundary) it deems necessary which meets primary care requirements; (as per locally agreed pathways), and meets the timeliness and quality of reporting requirements of the specification;
- Ensure that service users are appropriately managed in the community;
- Improve access to the most appropriate clinician by delivering care closer to home and avoiding unnecessary hospital appointments;
- Integrate the clinical pathway between MSK Disciplines, Health Sectors and Third Sector
- Establish effective working relationships and provide evidence of referral to suitable partners to relevant interfacing services e.g. Podiatry, Stop Smoking,

weight management, and Third Sector providers etc.

- Self-management advice and education to be a major component of this service;
- Reduce risk of co-morbidities associated with back pain such as depression, social isolation and loss of employment;
- Improve psychological well-being, social functioning, and every day activities; and;
- Build on skills and confidence of General Practice staff in the physical assessment, initial diagnosis and management of service users who are appropriate for primary care management aligned with core pathways in general practice;
- Deliver a safe, quality service in line with the Commissioner's strategic aims and goals;
- Achieve value for money in line with the CCG QIPP Plans, whilst at the same time ensuring that service users are treated appropriately to their needs;
- Maximise the use of SFSDM through the appropriate management of MSK conditions;
  Ensure orthotic consumables are provided when appropriate
- Provide elective care services for 100% of patients that have attended an urgent care service (that would of previously have been agreed to attend an outpatient orthopaedic clinic) with back pain and/or soft tissue injury;
- The service is to develop pathways with local urgent care services to ensure that appropriate patients are offered the correct advice and treatment and asked to contact the Joint Health Service if their complaint has not resolved;
- The service is to develop the facility to offer patients; live online chat, telephone assessment, and individual face to face appointments or group sessions as appropriate.
- Work collaboratively with both CCGs to continuously improve and develop the service.

3.2 Service description/care pathway

The service will provide administrative and clinical Triage for service users aged 16 years and over. Service users aged 16 and over will be Triaged and signposted as per clinical pathway. The community based MSK service will treat service users with a range of MSK conditions affecting their neck; spine and lower back; and upper and lower limbs; including their feet.

3.2.1 Clinical Leadership

The service will appoint a Clinic Lead for the service who must be on the specialist register of the GMC with specialist training in musculoskeletal care or a Consultant Physiotherapist.

There should be no need for a service user to have to enter Secondary Care for treatment unless:

• Surgical/Medical intervention was required, the service user wants it and is fit for surgery
• Red flag or other serious pathology indicated

Early identification of service users with undiagnosed rheumatology conditions is considered necessary to this service model. This will ensure service users receive advice / early onward referral to Secondary Care (Rheumatology) as necessary.

The service must have a multidisciplinary team (MDT) will include a combination of workforce skills, including roles such as;

- Clinical Lead (as above)
- Extended Scope Practitioners (ESPs),
- Physical Therapists,
- Occupational Therapists (hands)
- Rehabilitation assistants and technical instructors
- Administrative input

Full range of diagnostic services to be commissioned by the Joint Health Integrated MSK Service, from which ever diagnostic provider it deems necessary, to provide the full range of diagnostics required and meets the timeliness and Key performance indicators (KPIs) required as per specification.

3.2.2 – Included pathways and conditions

The service shall treat the following conditions:

- All arthralgia, myalgia (small and large joint, soft tissue, muscular pain);
- Spinal pain;
- Mechanical arthritis (e.g. Osteoarthritis)
- Chronic regional or widespread MSK pain (e.g. Fibromyalgia, hypermobility);
- MSK related soft tissue lesions (e.g. tendon injuries, ganglion, Dupytrens contracture, trigger finger) Metabolic bone disorders (e.g. Osteoporosis, Paget's disease)
- Peripheral nerve entrapments (e.g. carpal tunnel syndrome)
- Sports Injuries;
- Other clinically appropriate conditions as per local agreement.

The service shall deliver integrated:

- Single point of Triage (administrative and clinical);
- Assessment (direct and non-direct);
- Onward referral (as appropriate if clinically necessary following SFSDM approaches having been fully applied and the patient has been deemed fit for surgery), to secondary care (orthopaedics/ rheumatology/ pain), in accordance with patient choice;
- Disease management and treatment including;
- MSK physiotherapy (exercise, mobilisation, manipulation, splinting, taping, electrotherapy and education informed and supported by research evidence, hydrotherapy where available);
- Joint injection therapy;
- Pain management;
- Provision of appliances/orthotics;
- Fitting service (including holding a supply) for splints;
- Possible inclusion of other evidence based / NICE approved physical therapies, for example Osteopath and Chiropractor Services;
- Service user support, advice and education;
- Referrer support, training and advice in the management of MSK conditions in primary care;
- All of the above will be delivered in line with current research evidence, NICE and Department of Health guidance. The Provider shall exclude 'red flags', as detailed in the model core pathways and clinical pathways (Appendix 1);
- Direct access to diagnostics (with a maximum 2 week reporting turnaround) including standard X-ray views (musculoskeletal ultrasound, musculoskeletal MRI, routine screening blood tests e.g. for inflammation, infection or underlying disease, routine pathology e.g. for microscopy and culture of joint aspirates, nerve conduction studies, CT and DEXA scanning etc.;
- Discussion re lifestyle, including recording of weight, BMI, and blood pressure and manual pulse check.

3.3 Care pathway - See appendix 5

3.3.1 Primary care management

Elements of primary care management should be managed across the GP localities/neighbourhoods – with appropriate annual training, or more frequently if needed.

Management of MSK conditions to be considered in primary care are detailed in the clinical pathways (Appendix 1) and will include:

- Pain management and drug therapies as appropriate according to national guidelines and agreed clinical pathway;
- Patient education, lifestyle and exercise advice;
- Carpal tunnel wrist splinting (with over the counter splints or first line splints to be provided by the MSK Community service);
- Joint injections (clinical pathways specify one joint injection to be administered in general practice before onward referral. To be delivered by an appropriately trained member of staff);
- Patient education, lifestyle and exercise advice supported by a high quality portal and leading edge IOS and Android Apps.

3.3.2 Referrals

Referrals are made into the single point of access (SPA) by GPs, A&E (Including A&E returns), and other community AHPs e.g. Nurse Practitioners, rehab teams etc. Each referral should be completed on the agreed electronic referral form containing the agreed minimum data set and be fully completed. Any referral received direct to secondary care if not a red flag or 2 week cancer wait must be returned to the Joint Health Service and the CCG/GP informed. Referrals are to be made electronically via EMIS or ERS.

The SPA admin team will undertake:

- Referral receipt / acknowledgment;
- Check that minimum data set has been completed;
- Booking and re-booking appointments;
- Text reminders routinely sent to 100% of patients that have a mobile phone contact number;
- Operate telephone queries line from 08.00 to 18.30 – Monday to Saturday;
- Book interpreters;
- Process discharge summaries and DNAs;
- Collate activity data, statistics and Key Performance Indicator (KPI) information.

3.3.2.1 Consider referral for surgery / to a specialist

The Provider will need to ensure that service users can be referred onto Secondary Care (providing independent offer of choice) if it is clinically appropriate ensuring that there is:

i. Functional limitations as measured on an evidential based scoring methodology agreed with the CCG;
ii. Improved quality of life (QoL);
iii. Non-surgical treatment has not been beneficial:
    - SFSDM approach has been used properly and outcomes of discussions documented;
    - Approved by an MDT;
    - Within the timescales set in the specification and compliant with 18 week referral to treatment (RTT) rules.

Clinicians responsible for referring a service user for consideration of surgery should ensure:

- The service user wishes to be referred and that they are fit for surgery using the locally agreed protocol;
- They refer before there is prolonged and established functional limitation or severe pain;
- The risks and benefits of potential treatment options should be communicated to service users in ways that can be understood;
- NHS decision aids have been offered.

It is vital that relationships with all local NHS and Private Secondary Care providers are built to enable confidence in this stage and to avoid any duplication in costs or delays for service users.

Seamless Care and Pathways

The Provider will need to:

- Co-operate and collaborate with other providers e.g. GPs, community and secondary care providers (NHS and private sector) to ensure that service users entering and exiting the service are managed appropriately;
- Develop protocols and guidelines with local GPs for the management of MSK issues to reflect the needs of their local population and to up-skill primary care professionals;
- Provide regular updates to the GP membership (every 3 months);
- Service to provide a summary report of all direct GP referrals to secondary care that are re-directed to Joint Health;
- Ensure GPs / Providers of onward referrals receive high quality information on the service user's clinical history/management plan within the timescales laid out in the specification;
- Provide timely onward referral to secondary care providers without any delay if service users fall into red flag (where not identified by GP) in line with national timeframes.

The Provider will make arrangements to obtain service user satisfaction feedback in relation to the service from service users as per locally agreed KPIs and will be expected to demonstrate evidence of having used the service user experience to make improvements to service delivery. The provider will be expected to use and separately identify the Joint Health Service on NHS Choices by no later than 1st July 2016 and actively promote NHS Choices for patient and carer feedback as a minimum. Providers should consider using service user focus groups to explore themed issues that are brought to their attention.

A simple user friendly electronic complaints and feedback procedure will be made available to all service users. Compliments and comments from service users are perceived by the CCG as equally important and should also be used to shape the service.

It is proposed that through an integrated care pathway, Service User experience, need and demand will be met by:

- Improving access to the most appropriate clinician through a single point of referral and central booking system;
- Triage from a standardised minimum data set referral form;
- Offering a six day clinical service and a 7 day admin service; extended hours and ease of access for patients;
- Physiotherapy can be offered from any suitable community venue; the optimum would be to offer this within all CCG localities; however the provider may take a phased approach to roll out (to be agreed with the commissioners).
- Timely and easy access to face to face patient centred assessment within no longer

than 2 weeks from referral and treatment which is based on identified need and risk;
- An integrated care pathway across clinical disciplines and health settings, provided in partnership with other services, which improve navigation and communication for the Service User and Referrer;
- High quality assessment, treatment, advice and education based on clinical need;
- Promoting quality of life and independence in relation to health and all forms of disability;
- Implementation of Key Performance Indicators ("KPIs"); process, outcomes and patient experience.
- Ensure that the 18 week referral to treatment (RTT) rules and cancer waiting time targets are applied in accordance with the current guidance;
- Utilise the CCG agreed clinical pathway guidance and support the development of further clinical guidance as required that is used as clinical reference when triaging referrals. Providing advice to primary care clinicians on the management of patients with MSK conditions.
- Prevent patients with long term MSK issues increasing demand on other services including referrals into secondary care.
- Deliver service user and referrer education.
- Ensure that the most appropriate community based treatment is offered based on clinical need, but where secondary care intervention is required - surgical conversion rates to be agreed as KPI.

3.3.3 Self-Referral

An option for patients to self-refer to should be available and would require an administrative Triage. Entry into physical therapies will take place only via the SPA. The model for self-referral will be via a telephone advice line, referral form completed and submitted via a web-based platform. The patient will be clinically Triaged and assessed by physical therapies. If the referral is rejected, either from the SPA or from physical therapies, the patient will be informed by the service and asked to return to their GP for further consultation. An example self-referral form is shown in Appendix 2.

3.3.4 Red Flags

Red flags are to be excluded from the Community MSK pathway and referrals should be made directly to the acute provider. Red flags are detailed in the clinical pathways and include symptoms and signs that are suspicious of;

- Suspected Cauda Equina Syndrome;
- Suspected cancer (follow 2 week wait pathway);
- Patients with acute, rapid progressive or severe neurological deficit;
- Trauma; acute trauma, suspected fracture, dislocation or infection;
- Acute tendon rupture < 6 weeks;
- Emergency conditions including but not limited to suspected septic arthritis, temporal arteritis; and
- Suspected organ damage related to an inflammatory rheumatic disorder or vasculitis (e.g. acute renal impairment, interstitial alveolitis, pericarditis, optic neuritis, digital ischaemia etc.) or systemic disease causing toxic symptoms.
- Inflammatory arthritis

3.3.5 Triage

The service will Triage all referrals (including self-referral see 3.3.3) either for self-management advice or to book an appointment if deemed appropriate following admin and clinical Triage. It must also look at other ways service users may want to access the service. Similarly for health professionals, an electronic single referral point must be available for all referrals.

Admin Triage: The purpose of the admin Triage is to ensure that the minimum data set has

been fully completed and that the patient is registered with a local GP. Any incomplete, inappropriate or poor quality referrals will be returned to the referrer (depending on entry route and locally agreed processes). All service users will be encouraged to complete an equality monitoring form prior to discharge.

All GP referrals should be directed electronically to the SPA via the agree pathways, except red flags and 2 week cancer rule (TWR) where referrals should be directed to the most appropriate acute provider.

Clinical Triage: The referral will then undergo a clinical electronic Triage to allow the referral to be directed into the appropriate service in accordance with agreed care pathways. Clinical Triage will be led by the ESP/ Clinical Lead for the Joint Health Service and be carried out by appropriately trained and qualified member, or members of the MDT. It should include assessment and/or advice, as appropriate to the referral, from subspecialties where appropriate, e.g. Extended Scope Practitioner (ESP). For avoidance of doubt, the patient is not required to physically attend the Service for the Initial Clinical Assessment of referral.

Following clinical Triage:

- A service user could be offered a course of treatment from health professionals such as physiotherapy, podiatry, orthotics, and patient education sessions etc.;
- A service user could be sent for diagnostic (imaging) for further investigations prior to the correct treatment pathway;
- A service user could be seen by a specialist MSK Clinician including input from the Clinical Lead/ Extended Scope Practitioner (ESP) (or a combination of all) including soft tissue and articular injections;
- Referral to other secondary care specialities for surgical procedures / medical intervention not within the remit of the service / red flags as per local policies;
- Referral to other community care services, for example, pain management, weight management, and Third Sector etc.;
- Referral back to the GP with advice re: treatment in general practice.

It is expected that the service will offer and provide the following (evidence-based) interventions in discussion with the service user:

• Education and self-management.
• Manual therapy - spinal manipulation, spinal mobilisation and massage
• Structured exercise/education programmes
• Joint injections (if not appropriate to be carried out in primary care by qualified GPs)
• Medication Reviews
• Combined physical and psychological treatment programmes
• Therapeutic Ultrasound
• Transcutaneous electrical nerve stimulation (TENS)
• Access to gym and hydrotherapy pool
• Assessment and fitting of bespoke and non-bespoke orthoses

Clinical Triage turnaround time is within 1 working day from referral receipt from the admin and clinical Triage process. The outcomes of the Clinical Triage will include, as appropriate:

- Prioritising review and accepting urgent referrals, offering patients an appointment within timelines outlined within the specification;
- Appointment arranged for Joint Health Service (directing patient to most appropriate member of the MDT to support patient receive right care first time);
- Ordering diagnostic scans or blood tests for the patient, under the direction of the appropriate clinician;
- Undertake a telephone, online assessment/consultation or video link where clinically appropriate and log contact and agreed outcome;
- Independent choice of provider for all patients that require treatment that can only

be done in a secondary care facility (Offer of choice out of scope of specification for Southport and Formby CCG);
- Directing referrals to a range of other primary care, community, lifestyle or Third Sector service;
- Referral to other services e.g. Podiatry, Dietetics etc.

Bookings for a face to face assessment/treatment are to take place following clinical Triage. Service Users will be given adequate notice and a choice of appointment at their preferred site if available.

Waiting time following referral receipt to first appointment offered to patient must not exceed;

- weeks for patients Triaged to interface service
- 1 week for urgent physical therapies and;
- No more than 4 weeks for patients Triaged for a routine physical therapies appointment.

Clinical Triage to directly book into:

- Secondary care for red flag indications (where appropriate)
- Diagnostics following agreed pathways (where appropriate)
- Other services – associate services as indication in the specification (where appropriate)

3.3.6 Joint Health Service:

The service shall treat the conditions detailed in Section 3.2.2.

This service will provide:

- Clinical assessment, diagnostics, SFSDM, advice and support by the most appropriate specialist(s) within the MDT;
- Appointments allowing the patient time to ask questions and receive responses;
- Provision of information to the patient's GP on any non-MSK condition identified;
- If no MSK diagnosis is present, the patient must be discharged to the care of the GP with appropriate discharge advice and information;
- Screening for anxiety and depression in any patient with a long term MSK condition;
- Lifestyle and health promotion advice including; dietary advice, exercise promotion, signposting and coordination with other services e.g. mental health support, health trainers, expert patient programmes.
- Services delivered by the community MSK pathway should adhere to the agreed Clinical Pathways (detailed in Appendix 1).
- Appropriately skilled and experienced clinicians that have relevant skills and competencies.

Patients are clinically assessed, treatment planned and certain interventions may be undertaken as detailed above. Treatment, education and advice may be offered on a 1:1 or group basis as appropriate to the patient's needs. Diagnostics may be directly requested, including MRI. The patient will be re-assessed at any subsequent follow up visits and discharged according to **clear criteria** specified below.

Assessment

It is important service users:

- Are assessed using a bio-psychosocial approach using a valid/robust method (as appropriate (Arthritis Research UK MSK Health Questionnaire (MSK-HQ) will be used for all service users pre and post treatment);
- Take an active role in the assessment;

- Adopt self-management approaches suited to their preferred learning styles;
- Have thorough explanations and opportunity to ask questions

Bio-psychosocial approach should focus on three core elements:

- Biomedical factors
- Psychological factors
- Social functioning

Assessment should always aim to identify/exclude serious pathology / red flags.

The service will also be able to identify and manage through internal/external resources, yellow flags, such as:

- Attitudes - towards the condition
- Beliefs – beliefs/fears of the condition
- Compensation - payment for an accident/injury
- Diagnosis - Inappropriate communication leading to misunderstanding
- Emotions – e.g. on-going depression and/or anxiety
- Family – e.g. over bearing or under supportive.
- Work (or Benefits) – e.g. problems/absence
- Making Every Contact Count (MECC)
- Patient Activation Measures (PAM)

Service users that have identified yellow flags should be referred, if appropriate, to external services (health and none health) including early referral to community chronic pain services (where available) to try and prevent any chronic pain from developing.

Management (including review / on-going assessment)

Management should ensure:

- Bio-psychosocial evidence-based management (if appropriate);
- Service users receive full and up-to-date information (the risks and benefits of different treatment options should be communicated to service users in ways that can be understood). To include high quality videos (conservative treatment and clinical intervention) a quality portal and leading edge IOS and Android Apps;
- Use of appropriately prescribed and/or over-the-counter analgesia;
- Focused on self-management - service users keep active / referral to local physical activity initiatives or suitable alternatives;
- Signposting to sources of information and support;
- Planning and supporting return to work (for those not in work - maximise function and activities of daily living);
- Appropriate patients are given a fit note as per locally agreed pathway;
- Service users have reviews tailored to their individual needs (revisit advice and information given earlier to identify progress);
- Care planning (SFSDM) in partnership with the service user;
- Health professional dependency should be avoided;
- Tailored education about pain / exercise / self-management;
- Service users should be offered advice on primary, secondary and tertiary prevention e.g. NHS Health Check, increase physical activity and achieve weight loss if the person is overweight or obese.

3.3.7 Diagnostics

Arrangements for Imaging and Ensuring Results are Appropriately Actioned:

It will be the responsibility of the Provider to arrange for imaging to be carried out (MRI, CT -

MRI contra indicated, Ultrasound, X-Ray, MRA shoulder & hip, weight bearing X Ray - foot and ankle) using guidelines developed by the Royal College of Radiologists. Providers will follow recommendations under the headings of Indicated / Not indicated (as clinically appropriate) and that any requests for imaging under the Specialised Investigations / Indicated only in specific circumstances, or that are not covered by the guidelines, are requested in accordance with Provider developed (and Commissioner agreed) protocols. Providers must have the ability to audit imaging referrals when requested.

Key Requirements for Diagnostics (Imaging):

- Reasons for the request clearly stated, and sufficient clinical details supplied;
- Access to an appropriate specialist in radiology imaging for any queries;
- The report is communicated in a timely fashion;
- Both the referrer and the reporter need to have a 'safety net' system in place so that results are not misplaced;
- Service users should be informed as to how and when they will receive the results of their test;
- Electronic requesting and reporting;
- The Provider has a duty of care to ensure that results are followed up and appropriate management plans put in place;
- The Joint Health Service will be responsible for the cost of all imaging (as part of a wider devolved Joint Health budget;
- The Provider will be required to review, follow-up on results and ensure appropriate action is taken within 3 working days of receipt of requests generated from the service. This process will be stipulated in the Joint Health Service Diagnostics clinical guidelines and policy (Appendix 4); including auditing process to ensure that all staff notes and records are audited within a yearly cycle. Any unnecessary delays in receiving results from diagnostic services must be reported to the Commissioner and recorded and monitored within the Provider's tracking system;
- The preference for location must take into account patient choice (if available);
- If the MRI is being requested to exclude a condition prior to continuing therapy then the report should be approved by MSK radiologists;
- Images and reports are to be transferable and accessible to community and acute providers. (Reports are to be embedded into the image);
- Urgent scans should be available as a matter of clinical discretion. Examples of where this might be appropriate include red flags that were not suspected at the time of referral, severe pain refractory to adequate and appropriate analgesia, clinical deterioration where urgent imaging is important to determine diagnosis or management.

3.3.8 Education and training:

- The Provider shall provide support, training and advice to GP practices in the management of MSK conditions in primary care and appropriate community services on an ongoing regular basis without any detriment to access times for the services;
- Patients, GPs and other healthcare professionals must have access to telephone and email for specialist advice and guidance services throughout the period Monday to Saturday 08.00 to 18.30. The Commissioners expect the Service to turnaround these requests within 30 minutes for advice relating urgent requests. Advice for non-urgent requests must be provided within two working days.
- The Provider is required to work with local GPs and the CCG to provide relevant support and training to GPs. This will build upon the clinical skills for the diagnosis and management of service users with MSK conditions, as well as providing advice in the clinical decision making of the Service User's care.
- The Provider's support to GPs shall include a specific focus on health inequalities with the aim of reducing late presentation, and a reduced likeliness of referral to hospital, elective surgery and unplanned hospital admissions among socially disadvantaged service users.

3.3.9 Patient self-care

Patient self-care must be promoted through poster campaigns in GP practices, health centres, libraries. Posters should also highlight benefits and risks of conservative treatment measures and surgery. Patients must receive education and supported self-management plans; have access to high quality portal and leading edge IOS and Android Apps.

Self-care and management underpins all activities within this service. Self-management information will be available, from the service, even before the service user has accessed the service. Service user education should commence early in the process and certainly at the first assessment. It should not just be considered as giving service users information in the form of leaflets, but be in a suitable format for them to understand based on their preferred learning styles. Information given should include local, national, and third sector organisations. The default being to promote the use of the high quality IOS/ Android Apps and website portal developed for the Joint Health Service.

Information sharing should be an ongoing, integral part of management, not a single event. It should enhance understanding of the condition, its management and counter misconceptions as well as empower service users to use their own knowledge and skills to access appropriate resources.

The Provider will be expected to have in place by 1st July 2016 fully functioning/operational high quality IOS/ Android Apps and website portal for service users and health professionals to obtain information about the service, treatments available, and also how to contact the service (along with useful information about self-management / lifestyle factors etc.). The website will include daily, weekly and monthly performance dashboards to indicate to stakeholders how well the service is performing. In addition the Provider shall work with the Commissioner to ensure links to other NHS and non NHS websites are provided.

The service will make available to service users the agreed procedure for booking appointments and the policy on DNAs and cancellations. Information will be formatted accordingly and will be made available in different languages / formats as required. The service will follow the Accessible Information Standard guidance.

Patient self-care must be promoted through education, supported self-management plans and SFSDM. A variety of tools and techniques should be utilised to support patients in understanding their conditions, what the treatment plan may be and that they are involved along the pathway of care. A specific focus on patient support and care planning for patients with long term conditions is essential.

Engagement with the patient should incorporate a question around employment status and their desire to recover their health and remain engaged with work; and offer support to people who have been out of work due to a MSK problem to make successful return to meaningful work.

On discharge from the Service, patients should receive care-planning support, supported by a self-management care plan. This will describe the patient's self-care action plan and a copy will be held by the patient, the GP as well as the Service. The care plan should be developed jointly with the patient, respecting the clinical opinion and advice, and be inclusive of maintenance, exercise and other relevant advice (e.g. diet advice). More complex patient's care plans may be loaded onto the Joint Health EMIS Community Web health record system.

3.3.10 Joint Injections

Delivery in accordance with agreed clinical pathways, detailed in Appendix 1. General guidance for joint injections is for one steroidal injection to be administered in primary care by an appropriately trained member of staff. If this does not have satisfactory clinical outcomes, the patient will be referred into the Joint Health Service for onward care and

treatment.

3.3.11 Solution Focussed Shared Decision Making

Solution Focussed Shared Decision Making (SFSDM) is a key component that underpins the Service. SFSDM will be promoted by the service, and may involve signposting patients to the national Patient Decision Aids and online tools to supply information and advice to patients and guide and support them through decision making.

3.3.12 Discharge Criteria

Acceptable discharge criteria are as follows:

- Resolved;
- Optimum outcome following treatment/ advice achieved;
- Patient able to self-manage;
- Patient able to manage condition with exercise programme;
- Patient failed to attend for initial appointment or full course of treatment in line with the DNA policy;
- Patient declines to participate in recommended evidence based management;
- Patient requires referral to another discipline or back to original referrer;
- Referral back to GP for further management with advice;

Information provided to a patient's GP at discharge should include:

- Patient identifiable details (patient number / name);
- Date of attendance and discharge;
- Investigations carried out;
- Summary of findings (including diagnosis);
- Information provided to the patient;
- Management plan;
- Medications initiated or terminated; and
- Follow-up arrangements.

3.3.13 Onward referral from the Service

Direct referrals can be made from the Service to hospital care for MSK related conditions. Where onward referral to hospital based care is required (e.g. for surgery/ suspected cancer), the Service will be required to provide:

- Independent choice of provider for patients. This is to include appointment times and dates for the selected providers with the patient; detail of the facilities and services offered by each provider (Service contracted separately and out of scope of this specification for Southport and Formby CCG);
- Notification to the patient's GP no later than 24 hours;
- All diagnostics results and patient notes under agreed information sharing arrangements with hospital providers to prevent diagnostics duplication; and
- Processes and pathways for rapid onward referral of patients with suspected malignancy, under The NHS Constitution rights for patients with suspected cancer , ensuring follow up with the receiving provider to ensure the referral has been received and actioned.
- The Service must have in place pathways and processes for urgent referral to A&E for emergencies.

3.3.14 Care Planning and Multidisciplinary Care Delivery

The specification requires the service to be provided in a setting where the patient may also be receiving other aspects of MSK care at the same time. Individuals will experience

coordinated, seamless and integrated services using evidence-based primary care pathways, full implementation of SFSDM, self-management, case management and personalised care planning.

Effective care planning and preventative care will anticipate and avoid deterioration of conditions. The specification requires the provider to work with other parts of the health service, e.g. secondary care providers, mental health, and third sector. Patients will be referred to the relevant professional, experiencing coordinated, seamless and integrated service.

3.4 Information Technology

The CCG requires the Joint Health Service to use EMIS Community Web to deliver the service as is used on other services within primary/community care in the local health economy. If however the service provider does not use EMIS Community Web it is the responsibility of the provider to ensure that their clinical system is interoperable with EMIS Community Web. Any costs for achieving interoperability should be borne by the service provider.

The Provider will be responsible for the provision, maintenance and cost of all Information Management & Technology (IM&T) hardware and software, licenses and IT support services required to meet the needs of the Service. These will need to meet local and national standards and support CCG's direction of travel regarding interoperability.

The Provider must ensure that appropriate "IM&T Systems" are in place to support the Service by no later than 1st October 2016. "IM&T Systems" means all computer hardware, software, networking, training, support and maintenance necessary to support and ensure effective delivery of the Services, management of patient care, contract management and of the organisation's business processes, which must include:

- Clinical services including ordering and receipt of pathology, radiology and other diagnostic procedure results and reports;
- Prescribing;
- NHS E-Referral Service (or any future replacement);
- A single electronic patient health record for every patient, which is identifiable by a unique number (e.g. patient NHS Number);
- Inter-communication or integration between clinical and administrative systems for use of patient demographics;
- Systems for referral management and booking for both GP referrals to the Service and onward referral from the Service to a specialist.

The service must use appropriate technologies for Managing call traffic to the service:

- Main telephone system (PABX)
- Automated call distribution (ACD)
- Interactive voice response (IVR)
- Customer announcements
- Call recording
- Dealing with calls
- Customer contact management
- Scripting
- Case-based reasoning
- Resolving enquiries
- Applications systems
- Intranets
- Workflow
- Document image processing

- Geographic information systems

3.5 Prescribing

The Service must provide patients with prescriptions for new medications or amended doses (or provide a supply if the Provider has the legal and supply framework for this from the Service locations). At least 28 days of supply should be prescribed to allow information to be provided to the GP regarding the outcome of the appointment and any changes in medication (initiated, dose changes, terminated) to be communicated in time for them to prescribe any required on-going medication to the patient. Where patients are required to be stabilised on treatment before prescribing is transferred to a patient's GP (e.g. DMARDs) the Provider will be responsible for prescribing and monitoring of the patient until this time.

The Service must comply with the local Formulary and the local Management of Infections Guidelines and any other relevant guidelines that the CCG will provide as appropriate and relevant to the service. The Provider will be responsible for all prescriptions including prescribing 'Red Drugs'.

It may be appropriate for the service user to obtain some medications from their local pharmacy on advice from the service. It is therefore a requirement for the service to have a good understanding of local Pharmacies and to signpost suitable patients for a medicines use review (MUR)/ new medicine service (NMS). The provider will also provide contact numbers, website details, maps and opening hours of local Pharmacies.

The Provider must ensure the safe and legal storage and disposal of medicines and prescriptions.

3.6 Service Level Agreement targets

The MSK service should be:

- Offered between a minimum 08:00 and 18:30 Monday to Saturday for clinical services and as a minimum 0800 and 18:30 Monday to Sunday for administration/ service registration;
- Flexibility with regard to days, times and sessions held (e.g. extended hours) to reflect modern working commitments and to encourage maximum levels of attendance is supported;
- Routine treatments must be offered within no longer than 4 weeks of referral receipt;
- Urgent referrals must be offered an appointment within 1 week.

Minimum reporting and data collection requirements:

- Referrals from clinicians must be made on the agreed Joint Health electronic referral form, containing the agreed minimum data set (as shown in Appendix 3) and sent to the single point of referral.
- For each patient contact the provider must record:
  - Patient identifier, DOB, gender, ethnicity, postcode, GP
  - Prescribed medication (Y/N)
  - Date of attendance
  - Treatment/advice
  - Investigations
  - Alterations in prescribed medication (Y/N)
  - Care/management plan agreed (Y/N)
  - Outcome

3.7 Population covered

The MSK service should be available to the following:

- All patients registered with Southport and Formby CCG member practices
- All patients temporarily registered with a Southport and Formby CCG member practices

3.8 Any acceptance and exclusion criteria and thresholds

Exclusions:

- Patients who do not have a suspected MSK condition
- Patients under the age of 16 for interface service
- Patients under the age of 16 for physical therapies
- Patients requiring inpatient care / day-case services beyond simple procedures and outpatient infusion / injection treatments provided by the community MSK service
- NHS England Prescribed Specialist Commissioning Services
- Patients requiring home visits
- Red flags as detailed in Appendix 1

3.9 Governance Requirements

Clinical Accountability

Whilst the overall clinical responsibility of the Service User resides with the registered GP, the Provider shall be clinically responsible for the episode of care that is administered to the Service User. Further, the Provider shall be responsible, and accountable, for all aspects of the work of its Staff, including the management of Service Users, in accordance with the GMC, NMC, Health Care Professionals Council and Chartered Society of Physiotherapy and College of Osteopathy codes of ethics and rules of professional conduct.

There must be clear and accountable governance arrangements with senior independent clinical leadership to provide accountability over care provided within the Service with appropriate presence at Service delivery locations.

Workforce

- The provider must ensure that all staff delivering the service are competent to do so
- There must be an appropriately qualified health care professional, named as the service lead who has overall responsibility for ensuring the service is delivered in accordance with the specification
- It is the responsibility of all staff delivering the service to remain up to date with all relevant training requirements. Members of staff that have been out of clinical practice for an extended period (e.g. 1 year) should seek guidance from their appraiser and/or relevant professional body regarding appropriate re-training.
- Staff delivering the service must be trained on all appropriate policies relating to the delivery of the Joint Health Service
- Staff undertaking any procedures must have verified Hepatitis B protection
- Staff undertaking any procedures must be CPR trained (adults) when they start to provide the service and should attend annually thereafter.
- Adhere to national recommendations and requirements regarding education and training

Minimum clinical governance requirements

- There should be a clearly documented process to support the management of the Joint Health Service.
- In addition to those referenced within the main body of the standard contract, the provider should have policies covering:

- Infection control procedures
- Needle-stick injury management (including access to fast track management)
- Clinical Waste Management

Health and Safety:

- The provider should ensure that the service is delivered from suitable locations;
- The provider should ensure the service is delivered from suitable clinical rooms;
- The provider should undertake a risk assessment of the room that they intend to deliver the service from ensuring that they assess for the risk of collapse and any other reasonable foreseeable circumstances;
- The service should be provided in a room with a couch and a sink ;
- The service should be provided in a room with a panic alarm system;
- All standards of communication should adhere to Caldicott and Data Protection guidelines;
- Non-patient identifiable data generated in the course of delivering the service should be available to the commissioner on request. The commissioner will give due regard to data protection and confidentiality requirements;
- If required to ensure that the service is operating effectively, the commissioner can interview the service provider's staff.

Minimum Information Governance requirements

The Provider will ensure that all information sharing guidelines and protocols are abided by to maintain the safeguard of service user identifiable data. The Provider will take account of:

- Data Protection Act requirements;
- NHS Code of Confidentiality;
- The NHS Standard information governance policy
- Informed consent; and
- NHS Connecting for Health's care records guarantee.

If there are any concerns regarding the safe transfer or use of service user identifiable data, then these should be reported as a Serious Incident and referred to the local Caldicott Guardian.

3.10 Interdependence with other services/providers

Referral sources

- Referrals can be made by GPs, other Community and urgent care centres
- Self-referral by patients to the physiotherapy service (via clinically appropriate Triage route)
- The Provider shall have in place appropriate interface services, such as: diagnostic providers, podiatry service, community psychological therapy services, dietary services, exercise on prescription and other lifestyle interventions e.g. health trainers.
- At point of referral, the provider is to ensure that where necessary, Service Users can access interpretation services;
- At point of referral, the provider is to ensure that where necessary all imaging services shall be available for service users to be referred on for imaging within specified timescales.

Interdependencies

- GPs
- Consultants in secondary care
- CCGs
- Diagnostic services

- Acute Settings
- Tissue Viability Service
- Practice Nurses
- Bio-mechanical podiatry
- Dietetics
- Weight management services
- Smoking cessation services
- Third Sector
- Mental Health Services
- Community Occupational Therapy Services
- Local Authorities
- Community Health Services
- Rehabilitation services

To assist with integration and multi-disciplinary working, the Provider will host regular clinically-led multi-disciplinary team meetings including relevant clinicians from other services (MSK leads in GP practices and from all local NHS and private secondary care providers) to discuss patient care pathways and integrated working.

Coordination with Primary Care

The engagement and support of local GPs will be vital to the success of the Service. The Provider will work effectively with local GPs and GP networks, including:

- Keeping GPs informed about the diagnosis, care provided, plan for ongoing care, expectation of practices in primary care (including review dates);
- Support GPs / GP networks to develop primary care MSK leads;
- Ensure adequate medication information in accordance with the specification is provided at discharge from the service to support medication review by local GPs and pharmacists; Involve clinical networks in the on-going development of services;
- Involving primary health care teams in delivery of care (including shared care arrangements); and
- Education and skills development of GPs and the wider primary health care team, and support for condition management in primary care.

The new service will be accessible for local GPs, who will be able to ask for advice and guidance via the live chat facility, email (or through an arranged phone call) before or instead of referring a patient.

3.11 Patient Engagement and Experience

The Health and Social Care Act (2012) underlines a commitment to put patients at the centre of care delivery by providing them with better information, more choice and a stronger voice. All major policy drivers make it clear that good practice in patient experience must be embedded, for example a patient panel, in reviewing the service so that the views of patients and the public are heard and inform decision making.

The NHS Outcomes Framework 2011/12 sets out a clear framework for driving improvement in the quality of patient experience and outcomes. Alongside the Framework sit the Care Quality Commission's Essential Standards which outline how the NHS can provide the services and experience that patients expect.

The Provider of the Joint Health Service will be expected to involve patients, carers and the public in the planning and monitoring of the service, including any future developments throughout the contract term. Patient satisfaction with the service will be monitored before the patient finishes their episode of care to achieve the agreed response rate. Of the agreed percentage of patients responding, they will report their satisfaction of the service as either excellent or very good (with a range of responses to also include ratings of average, poor and terrible).

The provider will be expected to use a range of feedback mechanisms both during and post treatment/ contact for example:

- NHS Choices
- EQ-5D or MSK-HQ
- Keele MSK PROM
- Friends and Family Test
- Patient Activation Measures (PAMs)

The Provider will be expected to act upon patient feedback in all its forms including the provision of a clear complaints procedure, and make adjustments as appropriate to ensure they continue to deliver a high quality patient centred service.

It is the provider's responsibility to ensure that a variety of mechanisms exist, are supported, and resourced to enable patients to give feedback on the service and also to report back on actions taken and how the service is improved as a result. All patient engagement should form part of an audit trail to ensure the quality, transparency and integrity of the process. The provider is expected to audit 1 in 10 patient journeys utilising peer review and active learning sets.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

 The DH MSK Services Framework (2006)
 NICE Guidance, Osteoarthritis; The Care & Management of Osteoarthritis in Adults. Feb 2008
 NICE Guidance, Rheumatoid Arthritis; The Management of Rheumatoid Arthritis in Adults. Feb 2009

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

The following is not an exhaustive list; providers will be expected to adhere to all relevant guidelines:

- Procedures carried out to UKCC nursing standards
- National Service Frameworks where applicable (Long Term Conditions, Older People)
- Procedures carried out to Royal College of Physicians standards
- The Chartered Society of Physiotherapists – Quality Assurance Standards, 2012
- Health Professions Council – Standards of Proficiency; Physiotherapists, 2013
- Royal College Nursing– Integrated Core Career and Competence Framework, 2012
- Pain society and faculty of Pain Medicine at the Royal College of Anaesthetists- standards for care of pain generally and pain management programmes etc.

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

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

5.2 Applicable CQUIN goals (See Schedule 4E)

6.	Location of Provider Premises

The Provider's Premises are located at:

The service provider should deliver services from sites locally defined by both commissioning organisations (Southport & Formby and West Lancashire CCGs). As a minimum there should be initially two sites (one site to be held outside of the hospital setting), moving to five sites for Southport and Formby CCG (four sites to be held outside of the hospital setting) and four sites for West Lancashire CCG (three sites to he held outside of the hospital setting) over the course of the contract.

7.	Individual Service User Placement

Not Applicable

Appendix 1

Pathways to be agreed in conjunction with CCG clinical leads

Appendix 2

Self- referral form – provider to develop

Appendix 3

EMIS referral form (in development)

Appendix 4

Diagnostics clinical guidelines and policy – provider to develop

Appendix 5

Draft - process map MCAS new spec +.pd