Creating the Conditions for Improving Function

Creating and Sustaining Excellence (CASE) in MSK Care: A CASE for Change

Sussex MSK Partnership Central

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The Current System: Global, National and Local Picture

Global Picture

Musculoskeletal (MSK) pain conditions are one of the leading contributors to disability worldwide with an estimated 1.71 billion people affected. This figure is set to rise on a backdrop of an ageing population and increasing prevalence of non-communicable diseases (NCDs) such as diabetes, cardiovascular disease, cancer, and chronic respiratory disease (Briggs et al 2021, Finucane et al 2023).

Many musculoskeletal conditions share risk factors common to other non-communicable diseases, such as obesity, poor nutrition, and a sedentary lifestyle. Individuals with an MSK disorder are at increased risk of developing NCDs (Williams et al 2018) with an increasing prevalence of MSK conditions co existing alongside other NCDs (Simões et al 2017).

National Picture

MSK disorders affect around ten million people across the UK and account for the fourth largest NHS programme budget spend of £5 billion in England. We now know that they account for the biggest part of the workload of the health service, 40% of which is due to potentially preventable risk factors.

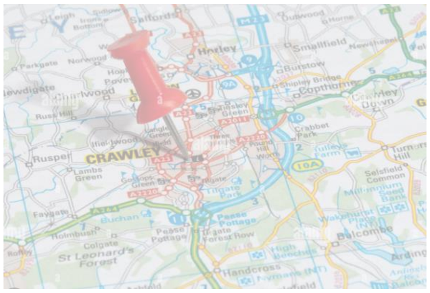
The impact of MSK pain and disability may have significant negative effects on the quality of life of millions of people in the UK; 10.8 million working days are lost because of musculoskeletal conditions (PHE 2019) and they are associated with a large number of co- morbidities, including diabetes, depression, and obesity.

MSK conditions present a significant challenge for the population, clinicians, and commissioners of healthcare services. They are reported to affect 1 in 4 of the adult population in the UK (PHE 2019). MSK conditions account for over 20% of all presentations in primary care (Keavy 2020). Over 25 per cent of all surgical interventions in the NHS are MSK related, and this is set to rise significantly over the next ten years (Arthritis Research UK 2013).

Around 20% of our lives are spent in poor health, we are now living with more complex illnesses for longer. This trend is set to continue as the proportion of those aged 65 and over with four or more diseases is set to double by 2035, with around a third of these people having a mental health problem (Prevention is better than cure 2018). Better health reduces the pressures on the NHS, social care, and other public services (Prevention is better than cure 2018).

Local Picture

As a result of underfunding from austerity and exacerbated by COVID, access for people with MSK conditions is harder than it has ever been locally.



Despite mobilisation of First Contact Practitioners (FCPs), across the vast majority of Primary Care Networks (PCNs), providing thousands of additional hours of highly skilled MSK specialist workforce into primary care, people can still struggle to access timely advice and support.

Community service waits, on average, more than doubled, whilst rapid access to specialist care is one of the key tenets of a successful community-based model aiming to support conservative management. If surgical intervention is required, this is extended further, often to well over a year. People are arriving to appointments with increasing complexity and chronicity, colleagues (clinical and administrative) are often feeling the impact of longer waiting times as well as increased incivility towards them. They, as much those requiring care, bear the weight of the wait.

The system has been in recovery for a long time and the strains of this, in addition to the 'business as usual' demands, present a challenging professional experience. There is a real risk, that when we are in this space, the focus is to just do more of the same, rather than thinking how things could be done differently. The fear of exacerbating waits leads to risk-adverse behaviours and can dampen the spirit for innovation. We have noticed over the years, an increased mechanisation of processes and a drive to industrial efficiencies, increasing complexity and not always adding value for the people it is supposed to serve.

We have evidenced the incredible impacts that personalised care has on people and the system. The transformative experience this has on those receiving and delivering care when the conversation shifts from 'what's the matter' to 'what matters to you'. There are financial and quality impacts of more people having interventions they may not understand, want, or need.

We have shown what true patient leadership and engagement looks like, with the demonstrable value of co-production. This work is much more than a tick-box exercise in our service.

Through focusing on data, we can see who in our communities we are serving, and crucially who we are not. Then we can use this data to start asking questions on why and what matters to design services differently to address any health inequalities.

We know from national research that those from black, Asian and minoritized ethnic backgrounds and more deprived communities are waiting longer, especially for services like physiotherapy, where private access is more affordable. To give a sense of scale to this, one UK Trust reported those from their most deprived areas were waiting 8.5 weeks longer for surgery compared to their affluent counterpart. In the same Trust, those from minority ethnic backgrounds were waiting 7.8 weeks longer than white patients (HSJ Jan 2022).

From our conversations with system colleagues as part of this work, there was a largely shared sense that the if services continue as they are, they will not be fit for purpose in 5 years' time, approximately half do not think it will be fit for purpose in 2 years' time, most see it as fit for purpose now, but some do not. This is a subjective question, but an interesting lens on what colleagues see as the core purpose of MSK health services and the current climate following COVID.

Through the prime contract model, which we have held over the last 10 years, we have had flexibility built into the model and the time to strategically invest to achieve a paradigm shift away from unnecessary intervention to support people to self-manage. Traditional ring-fenced funding models are often accompanied by perverse financial incentives to over treat and over-medicalise people seeking care. We know that a minority of people will still need surgical interventions, and by supporting those for whom this is not the best option, we improve access for those people for whom it is. This is not about rationing care, this is about the simple acknowledgement that the person who knows most about their condition is not the expert clinician, but the person living with it.

The desired form of NHS contracting going forward in the advent of the Integrated Care Systems (ICSs), is much more focused on working together. We are part of this emerging picture of collaboration and have been using our experience over the last decade, and beyond, to inform design of MSK services into the future. This model will be more aligned to a pan-Sussex approach, seeking to reduce the inequalities across the county, whilst understanding that some functions remain best delivered at placed-based and neighbourhood level.

The Case for Change: What We Know and Why

Musculoskeletal health is critical for human function, enabling mobility, dexterity, and the ability to work and actively participate in all aspects of life. Musculoskeletal health. It is therefore essential for maintaining economic, social, and functional independence, as well as human capital across the course of life. Impaired musculoskeletal health is responsible for the greatest loss of productive life years in the workforce compared with other noncommunicable diseases, commonly resulting in early retirement, and reduced financial security (Briggs et al 2021, Finucane et al 2023).

Current evidence identifies that the majority of MSK disorders do not have a pathoanatomical diagnosis which explains an individual's pain. Structural changes on MRI are common findings in asymptomatic people. Findings on MRI which are attributed to the cause of symptoms can lead to fear avoidance behaviour and unnecessary surgical intervention (Lewis et al 2018).

There has been a recent call that MSK disorders be managed in a similar way to other long-term conditions (LTCs) since MSK disorders share the same risk factors. With education, lifestyle considerations such as sleep, smoking cessation, a well-balanced diet, and a graduated and on-going physical activity programme, and, when appropriate, pharmacological management.

The expectations and beliefs of those seeking care, that treatments can ‘cure’ the problem, often do not align with current thinking and can conflict with delivery of care. Clinicians need to be up to date on knowledge and skills that reflect best practice with a transition away from treating symptoms and towards targeting the underlying drivers and consequences of the disorder. This will require moving from a paternalistic biomedical model to a personalised care and therapeutic alliance ‘what matters most’ approach. Treating ageing populations with increasingly complex chronic and lifestyle illnesses requires more care and less cure, more wellness, more health promotion, and the generic ‘soft’ skills common in concierge-type health practices, and not the technical, pathology-based knowledge (Nicholls 2021).

Personalised care will only be truly possible if the current healthcare system moves away from a health system that treats ill health to one that promotes and prevents illness. Healthcare which is much more capable of understanding a person’s context beyond the specific condition they present, recognising the individual as an active participant in their own health outcomes and addressing the social determinants of health (Community powered NHS 2022).

Some musculoskeletal conditions will benefit from earlier diagnosis and early treatment to prevent further, needless disability, reduce pain intensity and improve quality of life (ARMA 2017). The healthcare system needs to more towards prevention with a shift in focus from curative to promotive, preventive, and rehabilitative healthcare.

There are two dimensions to prevention (UKRI Medical research Council 2018):

Primary Prevention

- Aims to develop or evaluate interventions (including strategies and policies) to maintain human health and prevent illness or injury from arising in the first place. In turn, this would stop people going down the path of ill health and the need to access services.

Secondary Prevention

- Also known as clinical prevention, is early detection, intervention, and support, focused on helping people to manage conditions, halt progress and prevent more severe problems developing, and live better lives.

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To improve the care of people with MSK conditions, in an aging population, we also need to consider where and how we reduce the burden of MSK conditions within the community. There is a clear benefit to shifting focus to help people to manage their MSK health as a long-term condition and to live well for a greater proportion of their lives.

A photo from one of our Big Conversations, linking with the communities we serve in their own spaces.

People's Stories: As It Is

Grace is 22. She is a first-time mum to her 4-month-old daughter. She has been experiencing lower back pain which is impacting on her ability to care for her daughter and manage a household in which she is the only adult. On sharing her pain with her closest friends, they have made Grace fearful she might have cancer to which Grace lost her mum in her teens. Grace already has anxiety, and this has made it worse.

After a couple of months, Grace plucks up the courage to go to the GP. By this point she is barely leaving the house and is feeling isolated as she no longer has any meaningful friendships as these have slipped away. Grace gets seen by a First Contact Practitioner, Amrita, a week later at her GP practice. Grace and Amrita have 20 minutes together. In this time Amrita assures Grace that nothing about her clinical presentation indicates she has cancer, whilst the back pain is of concern, the biggest thing impacting on Grace's life is the absence of a network: Grace doesn't have any friends with children. Amrita knows of a local pram walk in Grace's neighbourhood. Grace likes the idea but admits she is unlikely to go because it is all a bit daunting. Amrita is kind and understanding, Grace feels she can trust her and right at the end of the conversation, Grace tells Amrita that she cannot read or write, something, which she hasn't told any health or social care professional before. Amrita signposts Grace to local services for support and refers her to the community service. Grace receives a treatment plan of good quality care which improves her lower back pain over time through conservative management. She doesn't take up any other health offers, her feelings of isolation remain, and her mood is low.

Shane is 31, he lives with his wife and three children, works as a bricklayer, and plays the occasional 5 a side. He wakes up with significant back pain. He tries to go to work, because if he doesn't, he doesn't get paid and he brings in most of the household income. By lunchtime, the pain is too much, and he stops work. He agrees with his wife that if it's still bad in the morning he will do something about it. They are already concerned about the impact of the loss of his afternoon wages on the household purse, especially as the energy bill is due any day. The next morning it's still bad. He waits in the phone queue to speak to his GP practice; he gives up, looks online, and sees he can self-refer to the MSK service. This says he needs to wait for his pain to have been present for six weeks before he can be helped. His wife is in tears, Shane gets paid weekly and there is simply no way they can survive even one week without his income, let alone six.

Shane decides he must work regardless, he starts taking over the counter pain medicine just to make it to work. When he is not at work he is lying in bed, he can no longer play with his kids, and he has ceased all physical activity. For someone who is used to being so active, Shane is suddenly incapacitated, this is making his mood worse. Even with this effort, he is still only able to work about half of his usual hours because it’s all too much. He is worried he is going to lose his job for being unreliable. His wife is struggling to maintain her part-time evening job, as Shane can no longer look after the children, and she must be home to care for him as well as them. It is 14 weeks later when Shane is seen, and then he must wait a further month for an image of his back to come back. He does get some advice in the meantime which has helped but not enough for him to do his job.

It is 8 months later that Shane can work, whilst he was able to claim some benefits, the standard of living for his family has significantly reduced and he and his wife are over £3,000 in debt. His relationships are strained, and he fears that before the end of the year he will need to relocate his family 25 miles away to live with his wife’s family to save on costs.

Mo is 67, he is retired company Director and avid golfer. Mo lives alone with his dog following his divorce a few years ago and is very financially secure. He notices that by the time he gets to hole 16 on his favourite golf course, his back twinges a bit. Martin still meets his friends for drinks, and he has a good network, he eats out more than he doesn’t, and the dog walks are still no problem. One of his friends at the clubhouse is an osteopath who suggested he self-refer into the MSK service. After finding out he would wait ten weeks to be seen, he seeks private physiotherapy, by the time he is seen he no longer needs his appointment but attends anyway because his friend Peter told him he should get an MRI just to check. Despite the clinician saying he did not need any imaging, he insisted on it. The MRI came back several weeks later and after he was followed up, no further treatment was needed.

Principles and Ideas for Improvements

Within this section are some principles. These should be considered as the guiding stars which provide the direction of travel towards excellence in MSK care. These are the tests by which we assess whether we are on the right track.

Alongside each principle are a range of ideas as building blocks towards achieving these principles. Some ideas will support multiple principles.

These ideas are examples and by no means exhaustive. They serve to give a sense of scale, aspiration, and a very practical sense of what these principles would look like if we were getting it right. These ideas should feel inspiring and stretching, whilst still leaving room for others to augment, grow and add new ones, knowing that people closest to the impact of these are the ones best placed to inform them.

Principle:

We harness the power of community-powered health, knowing that connection to community is transformative to peoples' experience, care, and wider lives.

People do not need to be on an active care pathway to come into our hubs to access the communal spaces, such as a garden and café, which are also used to support peoples' rehabilitation or assessing their activity in real environments.

Hub spaces create employment and volunteering opportunities, providing a sense of connection and purpose, and a route of re-entry back into the workplace.

There are regular sessions in community centres, charities, and other spaces where people come together outside of clinical environments. Where possible these spaces provide events where people can access clinical assessment and advice, be offered therapy kit, or off the shelf splints and orthotics.

People are encouraged to join and form supportive communities, which may be online or in person. Colleagues can facilitate these with a view that sometimes they may step away when they are not needed but respond to the needs of the group.

Principle:

People know who we are when or before they need us. We have a range of ways and spaces for people to interact with us, outside of usual referral routes, meeting them where they already are.

Our clinic sessions in community spaces offer the ability to connect to a host of community and voluntary groups, housing, social care, and social prescribing. They could offer cooking lessons, recipe cards for low cost, healthy cooking, and exercise options.

These offerings are tailored to the communities in which they sit. For smaller spaces there may be two or three clinicians working alongside our administrative support which would help facilitate and include a social prescribing element. These mobile teams would offer assessment, treatment, and preventative advice.

There is a mobile clinic on a bus which reaches out to people who do not usually access services. This will provide prevention information, advice, assessments, and some treatments. The bus will be stationed at de-medicalised places such as supermarket car parks, community centres and public spaces, at the end of walking groups and pram group routes. This can have a particular focus on supporting our homeless population, where we have a high DNA rate for standard pre-booked appointments and the current system is dependent on them having an address.

Self-referrals can be from all people into the service, and this process is designed to be inclusive, available in more languages and forms and one of our non-clinical team have the time to complete it live with people when this is what those seeking care want and need.

We make our service visible online and in print through work with communities, so that citizens know who we are, what we offer and how they can access it.

Principle:

We create the environmental conditions for people to bring their best selves and engage in care.

Hubs (clinical sites where we run our clinics from) are community friendly and de-medicalised as much as possible. We use fresh perspectives on our spaces to understand how we can make low-cost improvements, so these environments are more user friendly for citizens and colleagues.

Our clinical teams are focused on the person in front of them and not the computer. Not having set appointment times support clinicians having the autonomy to ensure they undertake generative listening to the person seeking care. Information is captured to support good governance and clinicians have the skills to support this.

Our spaces are as bright, interactive, and accessible for everyone, including considering those with dementia and neurodiversity.

We bring down the physical barriers between us, including screens at reception and encourage an open-door culture for learning and connection.

People feel cared for as soon as they walk into our spaces, they are welcomed, offered water, there are people with the time to chat to about their day and journey in. We know that this kind of entry fundamentally shifts how people engage with discussions on their care. Colleagues welcoming people are connected to local events and groups and can talk to the benefits of the community the person is now a part of.

We plan our spaces with sustainability in mind as a talking point to connect over, linked to health.

Our spaces provide interactive opportunities to engage around creating MSK health and promotion. We have simple animated videos supporting key health messages playing in our waiting areas and communal spaces, with options for interactions.

Principle:

We connect with primary and secondary care to create understanding of mutual needs, goals, and perspectives, using data to inform elegant solutions at neighbourhood and place level. Knowing that growing connection enables the quality of care to be greater than the sum of its parts.

There is First Contact Practitioner (FCP) presence in every Primary Care Network (PCN). Creating equity of access and using this presence in primary care to grow MSK expertise, share understanding of benefits and challenges across the care pathway.

There is a close working link between the service throughout the network of FCPs and non-clinical teams, with key liaison colleagues and contact routes. These colleagues work to understand practice populations and pressures and co-create solutions for that PCN.

FCPs work with their PCNs and practices to stratify and support the top ten people with MSK needs where a more in-depth, personalised, and proactive approach will be offered where PCNs would value this service.

Data on use of FCPs will be shared in near time and help inform provision needs.

PCNs have access to information from the MSK community service on how their populations are accessing care.

There is a slick and timely route for primary care to have access to the information about people registered with them which is of value to the practice in holding their care.

People have direct online access to see details of their upcoming MSK outpatients and surgical contacts within secondary care.

Principle:

Delivering a programme of health education and prevention is key to MSK health of communities and we need to create financially sustainable routes to providing this in a way which provides value and impact for our communities for years to come.

There is an offer of MSK support and advice to corporate organisations, who pay a fee for this service. This is beneficial to the employer in reducing absences and promoting the wellbeing of their teams. Whilst reducing the burden of MSK conditions in the community and accessing populations the service may not otherwise see, income generation from this will be used to fund the schools' education programme.

There is a programme touring schools, providing key public health messages on MSK health and on how to sustain a healthy lifestyle, creating a generational shift in prevention. Seeking to work with those areas impacted most by health inequalities.

The work with schools also providing careers advice on professions and roles associated with MSK, colleagues advising students what being in their role has enabled them to do: go to the Olympics, get a job in the premier league, travel into space. From this we will develop a strong work experience programme for clinical and non-clinical roles and support mentorship opportunities.

There will be work with communities to tailor the offer and co-deliver specific programmes with education teams aimed at improving health and wellbeing with evidenced transformative results, such as the daily mile.

We are in partnership with non-profit leisure providers and create gym space which is accessible to those in the community who may not otherwise be able to afford it, which is subsidised by paying members. From this gym space we provide education, treatments, and support people beyond signposting to make active changes and reducing the burden of MSK conditions.

Principle:

We provide a service which is flexible and is there for people when they need help and how they want it, knowing that this does not follow a singular linear form.

We have a route for people to have direct access to a clinician for function and pain advice, either in person and via telephone or video. This is less formal, not a full assessment, more like a pharmacy approach and with less documentation.

We deliver care over increased hours in the week which supports those seeking care to do so in a way which does not impact on their income or other commitments in life.

We have drop-in clinical sessions available for people, building on the model used for 4:1 using a whole team approach. These sessions support learning and connection for colleagues and ease of access for people seeking care.

The process for off the shelf braces, splints and orthotics has been transformed. People can access what they need through a range of vending machines and pharmacies across our communities.

People arrange their own follow ups online or are supported by our team as needed to mitigate any digital exclusion.

We have a range of group consultations available which are not focussed on a specific condition, but around a broad area and to support the needs of specific cultures within our community.

Principle:

Our services are accessible and welcoming for everyone, with particular attention and consideration given to those who are often excluded or find access and engagement with health services difficult.

We provide and connect to services which support those who are blocked or perturbed from usually accessing health and social care, supporting people with insecure finances and housing, literacy needs and language support for people whose first language is not English.

We understand community and voluntary organisations who are succeeding in the areas we want to develop or could succeed with our support and reasonable investment.

We test and invest in real time interpreting technologies which work to give equity in experience and access for everyone in their virtual and in person interactions for their MSK care.

Principle:

Our systems are slick, using the latest technology. All our processes add value and additional support is provided to those who need it to navigate their care.

We optimise the use of text and email technology rather than post, always making sure we provide access equity by supporting those for whom this will not work. This reduces the time delays of letters, embedding links and providing a consumer experience aligned with the digital age.

People can press a button to request a call back at any time, instead of waiting to speak to us.

We use latest scanning and 3D printing technologies to support timely access to bespoke orthotics, rather than sending away for items to be made with weeks' delay.

We have one clinical template covering all appointment types. Instead of a multitude of tick boxes, clinical colleagues have guidance notes to support clinical judgement.

Letters are only produced when they add value for the care pathway. Clinicians add comments into a clinical section of referral documentation.

When any onward referral from the community service is needed, people can complete their own referrals, with support from non-clinical colleagues as required. This provides a sense of ownership and people can see that their own referrals have been sent and track progress from there on. This includes projected timescales and next steps We expect hyper transparency. There are digital routes to flag concerns and a live web chat available. Those who are unable to do this for themselves can access health coach support at any time.

Principle:

We seek to understand what matters to someone as early as possible when they need help.

People call in for a what matters' conversation, combining the current pathway of triage and first assessment. These conversations are initiated by people seeking care, building on their activation in their care and reducing failure demand of administrative resources. We offer a call back for those concerned with costs. These conversations model the learning of the continuing triage calls, they are not time-slotted, some may take 20 minutes, some may need an hour. These are held by an abundance of clinical resource with a wealth of skills in personalised care, health coaching, motivational interviewing, and behavioural change.

There are a team of advisors with social prescribing expertise on hand. These conversations will not just signpost but have the capacity to go on a journey with people, provide advice and support, and even attend activities with them. This resource is available to them from now on.

Following what matters calls, if people need to meet us in person such as have a physical examination, they are seen in a local community or voluntary setting or at one of our clinics or hubs. People can book their own appointments, online, or call us and be supported by one of our team, advised after the 'what matters' call how much time they need to book in for and what expertise they need to access to support them in the next phase. People are supported by health coaches as needed.

Principle:

We build therapeutic alliances which recognise and optimise the expertise that people bring to their own care.

Instead of thinking about care as signposting or referring on, we instead work alongside people on their care journey. Once trust has been formed our colleagues have the time and headspace to bring others into the therapeutic alliance.

We have rolled out personal health budgets for some conditions, based on a system of trusting people to know what supports them. This creates a route to use these budgets to access treatment which is not available within the evidence-based guidance for their condition.

Principle:

Key to our work in health education providing people information and support they need to improve their health and give them the ownership and agency to meet their needs.

We have created a series of short online modules for people to complete as soon as possible in their care journey. These set the foundations of what they can expect from the service and what we need them to do to be a partner in their health decisions and care. We ensure that this is not used as a barrier for care when people need it.

For those who do not have internet access or are unable to guide themselves through these alone, we have a team of advisors with health coaching skills who can call people and go through this with them.

When people join us, they gain membership to online services. Online spaces also enable people to assess their own levels of activation, fill in their own body charts and access prehab and rehab advice and support. People can form their own communities of those with similar interests, conditions, and lifestyles.

Principle:

We support our people to support all people. Our colleagues know what excellence in care looks like and how the work they do ensures this. They are enabled to make good decisions in caring for others and for themselves.

Every colleague has regular and high quality 1:1s/supervision alongside team meetings, supporting meaningful development conversations.

We encourage administrative autonomy; teams share responsibility for the prioritisation and completion of what needs to be done to best support the needs of people seeking care. This is built on a foundation of understanding the impact and value of each process and action.

Our Patient Care Advisors are enabled support people on their journey as administrative processes are automated. These colleagues will be trained in social prescribing and/or health coaching, as well as other specialist skills. Our advisors model a personalised care approach in their interactions as much as we would expect in clinical roles.

Clinical roles are weighted towards generalism over specialism at a ratio of 80:20. This ensures professional variety, maintenance of skills in addition to more robust workforce resilience. Critically, this supports continuity of care and reduces hand offs and siloed working.

Clinicians have increased autonomy over their diaries and how they work, using a system for them to log preference locations and tasks, against a pre-set criteria to support business needs. Requests are submitted at the beginning of the month for the following month. This way of working supports equity and guards against de-skilling. Scheduling technologies, such as those used in school timetabling, are used to support the administration of this rather than a manual process.

Colleagues feel that they can readily access the support of others and want to come to work they feel invested in, and the spaces have the kit they need to do their jobs well.

Principle:

Colleagues have the resources they require to connect, learn, and develop.

We bolster the sense of team connection, knowing the impact of increased disparate working from different sites and from home. We have consistent end of day group debriefs across teams' individual sites and connected to those working remotely. Creating time to share, reflect and learn, as well as supporting a transition from work to home life.

We have a supportive structure which creates comfort in moving away from defensive medicine and risk aversion, into one where people are supported to make the right decision.

We have a duty clinician who is there to support clinician in their decision making, supporting them rather than taking decision making away from them.

We have a training academy for our Patient Care Advisors and Managers, to ensure colleagues are onboarded well and maintain expertise and competencies and are tuned into the culture of the organisation to make good decisions aligned with this. This supports these vital colleagues to feel invested in and creates routes for progression in line with aspirations.

We have diversified our multidisciplinary team and developed a competency framework for professional groups such as Sports and Exercise Therapists. We have increased the scope and number of Technical Instructors. Building up clinic capacity outside of the already challenged MSK professional groups and creating routes for career progression.

Principle:

A buzzing culture of research and innovation means we have much to celebrate and share for the benefit of people beyond our geography.

We have an annual innovation competition, to inspire idea generation. Colleagues will be asked to collaborate with at least one other. There are prizes, including financial reward.

Colleagues have the time and space to engage in improvement and innovation projects.

Our research strategy thrives.

Principle:

We see the whole person and understand the importance of trust and continuity in care.

We no longer carve people up by anatomical pathway this is reflected in our telephone system, our letters and how we organise ourselves. Administrative teams are structured to support this principle of holistic care, whilst acknowledging the benefit of smaller, more intimate teams on connection and wellness.

There are no 'patient hand offs', colleagues hold people and invite others in to collaborate around their care. People will not move from physio to hand and wrist to spine for example, clinical teams will constellate around them.

People’s Stories: How It Could Be

Grace

Rather than telling Grace about the pram walk and moving the conversation on, Amrita has agreed to accompany Grace on it next week, as well as introducing her colleague Jenny, who can support her with literacy needs in a way which felt comfortable. Grace trusted Jenny because she was able to meet her initially with Amrita. The pram walk builds up Grace’s confidence, she now has several new friends with babies of a similar age who get together often, they regularly come into the MSK hub for a coffee. Jenny has also been meeting Grace at the hub and been using the café space to work with Grace on her literacy. It has improved so much that Grace has started some sessions working at the café, taking peoples orders was a big deal but it helped so much being in a place and with people she knew and wanted the best for her. She is looking forward to barista training next week and she pools childcare with her new friends to support her being able to work. Her sense of self-worth has vastly improved along with her anxiety. With increased exercise from this work and the walking group, she has lost weight, and is learning to prepare low cost, healthy snacks for her daughter who is now 1. She has not thought about any pain in months.

Shane

As soon as Shane got pain, he looked online and got a number for the MSK pharmacy, it says he can drop into a community centre about a mile away that afternoon and see a physiotherapist. He’d never been there before but the pain was so bad he wanted to give anything a try. He was greeted by Joan and after a wait of about 20 minutes, he met Ravi. Ravi talked through what he needed to do. He took 5 days off to focus on some gentle rehab but kept the joint moving with the exercises Ravi recommended, which Shane did diligently. He knew what movements to watch out for, how to best manage pain relief and what would support his body to best recover. This meant he could start work again a week later and do most of his job and he knows exactly what to do if it happens again. Whilst at the community centre he saw the youth club advertised and thought it might just be exactly what his kids needed and to provide his wife a bit of respite. Shane’s whole family connection to each other and the community and has grown closer as a result. He’s thinking about doing some football coaching next season for the kids in the community centre youth club.

Mo

When he made his self-referral, Mo was directed towards some online modules. Through these he learned that an MRI would unlikely be of benefit for him. He also learned about gym access through the MSK hub, and he decided to give it a go as knew there were trained sports and exercise specialists there who could be on hand if he needed it. It was cheaper than other gyms and it also felt good that his membership fees were helping others in his community to access a gym rather than boosting a corporation’s profit margins Besides the smoothies in the café were great. He didn't need an assessment, scan, or follow up and was confident in his ability to self-manage. What’s more he connected to an online community of people with shared interests through the MSK online hub and has joined a local rambling club for even longer dog walks with company.

A Roadmap: Strides in the Right Direction

To bring this document to life, it will be important to create the space and time to reflect, hone, and understand how people can get involved, everyone should feel a sense of ownership over this.

This is a longitudinal change. This will not all happen overnight. It will require consistent progress in this direction. There will be quick wins and there will be setbacks. There will be new ideas in light of new information, and we will learn and augment our path on the way.

Given the current system pressures, there is a clear need to create the headspace for all colleagues to engage with this. We need to move from a place of paucity, where the spectre of waiting times looms large over decision making which drives risk aversion and start to think what could be possible. Freeing up colleagues will create a snowball effect for further innovations down the track. With that in mind these are some suggested key steps:

Invest time and energy to increase admin capacity

Get the basics right, ensure that the current colleagues are satisfied in their roles. Ensure that good quality 1:1s and team meetings are in place. Create a training academy to support new starters and maintain skill and interest.

Create a programme of key projects which automate processes. Start with creating a slick process for people to self-book their appointments, if this is utilised by even half of people, then it will free up a significant amount of admin resources to focus on valuable and impactful work in supporting citizens, especially those who might need that extra bit of help.

Do a critical review of processes and understand what is taking time and not adding value.
Start to scope out how we can broaden the current PCA role to include the function of a health coach and/or social prescriber. Find those with the energy to experiment with this.

Build and retain clinical expertise

Get the basics right, ensure that the current colleagues are satisfied in their roles. Ensure consistent and high quality 1:1s, clinical supervision and CPD support.

Seek to diversify our clinical workforce, create a competency framework for sports and exercise therapists and explore how we might extend the capacity of technical instructors to build their expertise.

Listen deeply, understand the pressures, and start to test out the ideas for service improvement.

Experiment with different models of care

Pilot an event(s) in localities with the most challenging waiting times, use this to test some new ways of working and understand what people want and need. Understand how different environments impact on the interactions we have when we meet people in a non-clinical or non-traditional setting. Work through new ways of documenting conversations and what really adds value in the care we deliver.

Initiate community partnerships

Understand we will need to partner and learn from others. Build links across the community and with a non-profit leisure provider.

Our space matters

Connect with those who might be interested in coming into our space and providing education or making links for the benefit of citizens and colleagues.

Using the expertise of Health Builders to co-design spaces, make small changes, and use space for eye-catching, engaging, and interactive education opportunities.

Encourage colleagues to have conversations about keeping doors open to encourage connection and learning.

Provide facilities, especially non-clinical colleagues, to stand whilst working and move around, following the results of the wellbeing survey.

These are just the start. They are initial steps towards new and elegant solutions which inspire and are impactful for citizens and colleagues.

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