

Quality Account 2021/2022



*“Delivering integrated community musculoskeletal services to the Oldham GP population”*

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**Part 1**

**1.1 Our Quality Account**

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

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

Where improvements in quality are required

What we are doing well as an organisation

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

**1.2 Board Statement**

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

We welcome this opportunity to review our service during the reported year and to outline future improvements we aim to make.

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

* Clinical Governance Team
* Research team
* Information Governance Board
* Staff, service users and carers from across the organisation

**1.3 Key Successes and Innovation delivered in 2021/2022**

**Customer Service Excellence**

During 2021/2022 the service was accredited for the twelfth consecutive year with the Customer Service Excellence Award.

The assessment method was once again carried out remotely. We shared all evidence prior to the assessment and then held a series of Microsoft Teams meetings with the assessor and various staff who presented our Customer Journeys of improvement for the year.

This year’s assessment gave the Service 8 Good Practice Awards with no areas of non or partial compliance. All Areas of Compliance Plus from previous years were also carried over.

The table below shows a summary of the assessment.



Excerpts from the report are given below.

There are high standards set across the organisation and they continue to meet them in most cases. It is good to see that these results are published on the website. The December 2021 information is already posted.

There are high levels of customer satisfaction. PMSK gathers information via text and telephone .The latest feedback showed 95% of patients are extremely likely to recommend PMSK to friends and family.

PMSK management has continued to give staff welfare and wellbeing a high priority. They have made sure that they have kept in touch with all staff whether working at home or in the office to talk through any concerns they may have. To gain further information a staff survey was carried out last month. Once all the feedback has been received and analysed action will be taken to address any problem areas identified by staff. In addition, it was good to see that PMSK have continued to recognise and reward staff who have gone the extra mile in their work. They are chosen based on feedback from patients and colleagues on a monthly basis.

There are now more face to face clinics as the pandemic restrictions are relaxed. However, the lessons learned through having to use remote consultations are being taken forward and there is likely to be a hybrid approach in the future. This will be based on patient views as some have already said that they are more comfortable with telephone appointments.

The partnership is well established but continues to be proactive both in the community and nationally. The core clinical activities provide an excellent service and this year the assessor was shown the evidence regarding a number of projects. These projects demonstrate a culture that puts the patients first whilst looking for the most cost- effective solutions. They also demonstrate that the partnership is a leader in their field and seen as a model of best practice. The addition of a pharmacist and the work done on the Giant Cell Arteritis Pathway are further examples of how MSKP continue to enhance the service offering.

**User Experience**

We continue to achieve a significantly high level of feedback through friends and family feedback from our employees.

We pride ourselves in our extremely high levels of patient satisfaction and embed outstanding customer service in all training.

We have had 94% positive feedback from staff over the last year some of the top examples of comments from the friends and family staff survey are as follows:

*“I enjoy working for Pennine MSK and feel that they are a fair employer with excellent benefits and rewards and have kept all of their staff and patients safe during the pandemic.”*

*“Always looking for ways to improve the service, regular peer reviews and updates, good peer support.”*

*“Really lovely team environment, supportive of training needs and great communication.”*

*“Great place to work with great staff benefits and employers who care. The staff's well being has been put first throughout the challenging year with the pandemic, with flexible working and risk assessments carried out regularly to keep staff and patients safe.”*

**Quality Management Systems to Improve Capacity and support to staff**

We have a comprehensive suite of Information Governance policies, and the service is supported by a Data Protection Officer. All staff completed Information Governance Training annually.

We remain compliant the Data Security Protection Toolkit.

We have again continued with our cycle of regular reading and reviewing of important policies and documents for all staff.

We have an external health and safety adviser to support staff and we also have an infection control lead to give guidance to staff, this has been invaluable during the pandemic and will remain in place.

**Fracture Liaison Service**

We continue to provide the Fracture Liaison service to Oldham CCG patients. The service aims are to identify potential fragility fractures, assess bone health and offer appropriate treatment and lifestyle advice.

We continue to participate in the national audit of secondary fracture prevention by providing demographic, disease and outcome data. In the period April 2021 to March 2022 we identified 954 patients over the age of 50 who meet the criteria for assessment by the FLS team, this is an improvement on the previous year which was impacted by the covid pandemic.

**Virtual Consultant Clinics**

A strength of the service is the speed in which expert opinion an advice can be sought and we provide this through a variety of methods. We have several virtual Consultant Rheumatology clinics each week so that clinical staff can seek expert opinion for patients with potentially serious diagnoses. We also run a weekly biologics MDT so that patients can be discussed with the whole team and a comprehensive management plan agreed. There is also a dedicated osteoporosis virtual clinic which supports the FLS patients and our own patients. In addition, our Lead Orthopaedic Consultant provides speedy advice for clinicians working across the MSK pathway.

**Advice Lines**

We have updated out telephone system this year to more accurately direct patient to the correct person first time.

We provide advice lines for Rheumatology and Occupational Therapy which provide valuable support and guidance to our patients. This often results in the patient not needing to attend an appointment or enables us to bring patients appointments forward if necessary.

MDT meetings in Tier 2 of the Persistent Pain Service continue to provide invaluable support to staff who are caring for patients within the Persistent Pain Pathway. These meetings are held weekly and led by our GPwSI in Persistent Pain. Cases are discussed and a management plan agreed which is then shared with the patient and their GP.

**Pain Service Discussion Meetings**

These quarterly meetings enable staff to seek support and discuss cases which they have found particularly challenging. As the clinicians are working across various sites this is an important way of keeping the staff feeling a sense of team and to provide support and share experience with each other.

**Obesity Management**

We have continued to support patients with brief interventions to advise of the benefits of weight loss.

We offer referrals to slimming world, providing funding for a 12-week programme of attendance to support weight loss and self-care.

Most referrals are made following a face to face discussion with the patient. In the year ending March 2022 the referrals to Slimming World were significantly reduced due the increase in virtual appointments which affected the dialogue between clinician and patient. 127 patients accepted a referral to Slimming World.

**A Better Life**

We work proactively with the team at A Better Life Oldham to refer patients for help with many aspects of their personal lives. The service provides support on lifestyle, wellbeing, smoking cessation, weight management, alcohol reduction and intensive personalised support. This year we have made 85 referrals to ABL for various methods of support for our patients. We have also improved our coding templates to better capture these referrals and following meetings with ABL have set up a method of reporting the outcomes of our referrals to us from June 2022.

**Part 2**

**2.1 Update on Priorities for Improvement brought forward from 2020/2021**

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

**Priority1: Ensuring service quality, safety and enhanced user experience. Providing excellent clinical outcomes, and meeting and exceeding relevant standards and regulatory arrangements.**

We have continued the Friends and Family Test for all appointments across the service, using the feedback constructively to improve the service. We review all messages, SMS and voicemails, left for us on a weekly basis.

Engaging the staff with the feedback from patients is vital to us and we circulate all the comments weekly – often reflecting on a particular theme or giving some well done’s and thank you’s to staff who have been mentioned by name.

Our monthly Operational updates have a regular focus on some of the fabulous comments we receive. A few examples are below

Staff were friendly and helpful and my doctor is so lovely. Very professional but puts you at ease, might be going again soon and will look forward to it, I don’t think it could be improved

Every time I’ve been referred, either for Telephone Consultation or for Surgery Consultation the service as always been prompt, polite and helpful

Always a warm greeting from all staff concerned. Appointments on time and good clear conversations from all medical staff. A pleasure to be served by these dedicated people.

If any comment causes concern we use our automated system to message the patient back and ask them to ring us with more details so we can address the concern fully and provide feedback. This feedback is then used to improve the service where possible. We have a comprehensive complaints procedure and a very low threshold for the coding of a complaint which retains our high standards.

We are continually developing the Directors Assurance work to ensure we are improving and complying with all aspects of CQC regulations.

**Shared Decision Making**

Dave Pilbury, our Director for MSK Services continues his work as an Associate of AQuA. This renowned Quality Improvement organization provides training in personalized care across NHS organizations predominately in the North-West of England. This gives Dave access to sharing good practice and innovation in healthcare to bring these ideas back to us at Pennine MSK. It also means there is access to free training for our staff.

Dave will continue his role in improving existing Decision Support Tools and developing new ones.

**Rheumatoid Arthritis and Inflammatory Arthritis National Audit**

National Early Inflammatory Arthritis Audit is a national audit for patients seen in specialist rheumatology departments with *suspected* inflammatory arthritis. The aim is to improve the quality of care for people living with inflammatory arthritis by assessing the performance of rheumatology units across England and Wales against NICE Quality Standards. Table 1 summarises each quarter NEIAA audit performance in comparison with the four previous years.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| QS |  | Year 4 | | | | *Year 4*  *01/04/21 to 31/03/22* | Year 3  *08/05/20 to 31/03/21* | Year 2  *08/05/19 to 07/05/20* | Year 1  *08/05/18 to 07/05/19* |
|  | Qtr 4 | Qtr 3 | Qtr 2 | Qtr 1 |
|  | Total number recruited *n* | 54 | 49 | 37 | 51 | 192 | 114 | 270 | 263 |
| 1 | N patients referred within 3 working days | 30  (56%) | 22  (45%) | 21  (57%) | 26  (51%) | 99  (52%) | 62  (54%) | 160  (59%) | 131  (50%) |
| 2 | N patients seen within 3 weeks | 49  (91%) | 45  (92%) | 31  (84%) | 46  (90%) | 172 (90%) | 101  (89%) | 207  (77%) | 151  (57%) |
|  | N eligible for EIA FU | 8  (15%) | 8  (16%) | 6  (16%) | 12  (24%) | 37  (19%) | 23  (20%) | 51  (19%) | 53  (20%) |
| 3 | N started DMARD within 6 weeks\* | 5  (63%) | 5  (63%) | 3  (50%) | 7  (58%) | 22  (60%) | 16  (70%) | 36  (71%) | 20  (38%) |
| 4 | N received written info at baseline | 8  (100%) | 8  (100%) | 5  (83%) | 9  (75%) | 33  (89%) | 22  (96%) | 41  (80%) | 46  (87%) |
| 4 | N received self-management education at 3/12 (1/4 in arrears) | 4  (100%) | 14 (82%) | 3 (60%) | NA | 24  (86%) | 22  (96%) | 42  (93%) | 43  (90%) |
| 5 | N with agreed treatment target | 8  (100%) | 7  (88%) | 5  (83%) | 10  (83%) | 32 (87%) | 18  (78%) | 35  (69%) | 30  (57%) |
| 6 | N given advice line details | 8  (100%) | 8  (100%) | 4  (67%) | 11  (92%) | 34  (92%) | 21  (91%) | 43  (84%) | 45  (85%) |
| 7 | N that have had a formal annual review | NA | NA | NA | NA | 0  (0%) | 0  (0%) | 1  (2%) | 6  (11%) |

**Quality Reporting**

We report across a wide range of quality measures which include:

Incident Reporting

Healthcare Associated Infections

Complaints

Patient Experience

Workforce & Staffing

Compliance with Safety Alerts

Training Compliance

These reports are submitted at the end of each quarter, the table below shows the average monthly outcomes

|  |  |  |
| --- | --- | --- |
|  |  | **Average for 21/22** |
| **ID** | **QUALITY REPORTING REQUIREMENTS - NUMERICAL** | **Monthly** |
| **1** | **Incident reporting including lower-level overview as well as more detail serious incident reports** |  |
|  | Number of Serious Incidents reported (in line with NHS SI Framework) | **0** |
|  | Of reported SIs: Number of Never Events reported | **0** |
|  | Of reported SIs: Number of Duty of Candour Breaches | **0** |
|  | Of reported SIs: Number of Safeguarding Incidents - Adults and Children | **0** |
|  | Number of lower level Incidents reported (clinical and non-clinical) | **5** |
|  | Number of Regulation 28 (Coroner’s Prevention of Future Deaths) Notifications received | **0** |
| **2** | **Health Care Associated Infections** |  |
|  | Number of Healthcare Associated Infections reported (breakdown by type) | **0** |
| **3** | **Complaints** |  |
|  | Number of complaints received | **7** |
|  | Number of complaints acknowledged & responded to within required timescales | **7** |
|  | Number of complaints referred to ombudsman | **0** |
| **4** | **Patient Experience** |  |
|  | Number of compliments received | **197** |
|  | Number of patients referred to the service who have had their experience of using that service formally captured including the friends and family test | **707** |
|  | Percentage of patients referred to the service who have had their experience of using that service formally captured including the friends and family test | **13%** |
|  | Number of patients who reported a “very good” or “good” experience of the service | **525** |
|  | Percentage of patients who reported a “very good” or “good” experience of the service | **94%** |
| **5** | **Workforce & Staffing (including Medical Staff)** |  |
|  | % of staff with up to date appraisal completed | **100%** |
|  | % of clinical / patient facing staff who are absent from work through sickness | **1%** |
| **6** | **Compliance with safety alerts** |  |
|  | Number of National Patient Safety Alerts (Central Alert System) acknowledged within 5 days of target date | **3** |
|  | Percentage of National Patient Safety Alerts (Central Alert System) acknowledged within 5 days of target date | **100%** |
| **7** | **Safeguarding** |  |
|  | Number of safeguarding incidents / concerns reported | **1** |
| **8** | **Training Compliance** |  |
|  | Mandatory training compliance rates | **83** |
|  | Safeguarding Training compliance rates | **99** |

**Priority 2**

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

We have made further improvements to our Directors Assurance work as the Board of Directors felt it important that they were collectively assured of all aspects of the service including the CQC domains and outcomes. It was felt that this would not only ensure we all understood what was happening in the service but also help us identify further service improvements we could make to benefit our patients.

We achieved this by:

* Updating research on best practice for assurance
* Promoting a ‘Think Family’ approach to safeguarding
* Full understanding of all the CQC domains and data already collected within the service beyond the CQC domains
* Regular update and review of the Directors assurance template
* Lead Directors reporting back on their delegated domain
* Involving the wider team in reviewing our assessment against each domain and to provide challenge and ides to further improve.
* Produced an action plan across all five Domains to ensure ideas are converted into actions and measured.

**Priority 3**

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

Our Clinical Peer Review programme, which is held every 6 weeks, continues to be felt extremely beneficial to all staff as does our Persistent Pain Case Discussion Group.

The patient obesity management scheme, operated in conjunction with Slimming World, continues to be offered to all staff who have at least 7lb to lose to reach a healthy BMI.

To promote a healthy workforce, we continue to provide a supply of fruit baskets twice weekly to encourage staff to eat healthily. We fund 50% of gym/sports club annual memberships to encourage employees to partake in exercise and maintain an active lifestyle.

We are continuing with the MSK physio assessment service for staff. Any member of staff can complete a referral form which is then triaged by one of our MSK physio's and assessment slot offered for advice. This service has proven very popular with staff either to quickly resolve any minor MSK conditions or to signpost any further intervention that may be required.

We continue to recognise staff with an outstanding attendance record. As well as staff receiving an extra day annual leave for having no sickness absence in 12 months we also award those staff with an unblemished attendance record at 3, 5 and 10 years with monetary vouchers.

This year we produced a People Plan which aligns to the NHS People Plan but also gives a personal touch for our staff. We promoted this with staff and gained staff suggestions in how we can help them achieve a work /life balance.

In our latest staff survey 96% of staff said they would recommend Pennine MSK to family and friends as a place of work

We continue to offer blended working across the service with staff being able to undertake part of their role from home.

Staff who changed their hours to help the service during the pandemic have been allowed to retain these working hours which in many cases has helped them with child care arrangements and caring responsibilities.

**2.2 Priorities 2021/2022**

**COVID Update**

**User Experience**

We continue to achieve a significantly high level of feedback through friends and family feedback.

We pride ourselves in our extremely high levels of patient satisfaction and embed outstanding customer service in all training.

Due to the COVID 19 pandemic we have been unable to continue to carry out patient surveys due to social distancing, which have been undertaken monthly in the waiting area so we can speak to patients after their clinic appointment since February 2020. This is something we hope to reintroduce in the future when the situation with the pandemic changes

**Advice Lines**

We continue to use advice lines for Rheumatology and Occupational Therapy, all continue to provide valuable support and guidance to our patient population.

Despite the COVID 19 pandemic we have been able to resume MDT meetings in Tier 2 of the Persistent Pain Service who continue to provide support to staff who are caring for patients within the Persistent Pain Pathway and ensure that patient’s journey’s through the service are timely and that they are treated and assessed by the most appropriate clinician.

**Changes to the service**

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

During the COVID pandemic we have continued to review our priorities as an organisation in order to enable us to keep all of our staff and patients safe whilst at the same time continuing to offer a quality service and offer an excellent place to work.

We regularly complete risk assessments in line with government guidance to keep all patients and staff safe. The risk assessment is reviewed every two weeks and we encourage feedback from our staff at all times.

We have increased our face to face clinics to offer the patients a more appropriate assessment where needed. However we have also learned that telephone or video consultations can be just as effective and certainly more convenient for patients and so have continued to offer these as well.

We continue to update the staff handbook to incorporate all changes to processes and procedures as a useful guide to all staff.

**Priority 1**

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

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

We continue to use the video content on our website filmed by our Persistent Pain Physios so that patients can access the content and work at their own speed from the comfort of their own homes.

We will continue to build on our Directors Assurance work to ensure we are striving to continually improve on all aspects of the CQC regulations.

We work closely with our colleagues at NHS Oldham CCG and partners to contribute to providing improvements in the health and wellbeing of the Borough’s residents.

We will be working closely with the partner organisations across health and social care in Oldham, such as Oldham Community Leisure, A Better Life Oldham and Action Together Oldham to improve the wellbeing of the residents of Oldham.

**Priority 2**

**Rheumatoid Arthritis and Inflammatory Arthritis National Audit**

National Early Inflammatory Arthritis Audit is a national audit for patients seen in specialist rheumatology departments with suspected inflammatory arthritis. The aim is to improve the quality of care for people living with inflammatory arthritis by assessing the performance of rheumatology units across England and Wales against NICE Quality Standards.

We have continued to recruit and collect data for the national audit of RA and IA. This will inform our ongoing service improvement plans for patients with suspected RA and IA.

**Priority 3**

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

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

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

To hold a Persistent Pain team away day in July 2022.

To hold an all service Team Build in September 2022.

To update Our People plan to focus on supporting staff and their health and wellbeing.

To engage staff fully by sharing our Risk register and CQC domain work to ensure we capture ideas from across the whole team and collaborate with them to improve the service.

**Priority 4**

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

We plan to continually make improvements to our Directors Assurance work to ensure the board are collectively assured of all aspects of the service including the CQC domains and outcomes. This will ensure there is a full understanding of what was happening in the service and also help us identify further service improvements we could make to benefit our patients.

We have invested in training for our Clinical Governance Lead on Patient Safety and are already seeing benefits shared and are working to use a systems approach to reviewing incidents and complaints.

**2.3 National Clinical Audit Participation**

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

* The national RA audit as detailed in 2.1
* The **Fracture Liaison Service Database (FLS-DB) as detailed at Page 6**

**2.4 Core Services Clinical audit programmes 2021/22**

A rolling of programme of audit is established to monitor outcomes from carpal tunnel surgery with quarterly reporting to the Senior Management team.

* An audit of the Fracture Liaison Service
* Audit of NICE compliance to adherence to pathways for high cost drugs prescribed for RA, PsA and AS.
* Wrist audit by hand specialist physio to ascertain appropriates of investigations prior to referral to orthopaedic surgeon
* Audit of plain film requests prior to referral to orthopaedic surgeon for knee pain
* A working group Navigate continue to meet quarterly to review and update best practice triage guidance and referral pathways for our MSK and rheumatology pathways.

**2.5 Research Statement**

The following includes some schemes brought forward from 18/19 & 19/20 but were on-going or completed in 2021/22

**Project 1 The British Society for Rheumatology Biologics Register - Scheme commenced in 17/18 and is on-going.**

The purpose of this research is to assess whether some of the new biological treatments including: Benepali, Cimzia, Enbrel, Erelzi, Flixabi, Humira, Inflectra, Kevzara, Olumiant, Remsima, Remicade, Rixathon, RoActemra and Xeljanz used in the treatment of Rheumatoid Arthritis have a greater risk of serious side effects and long-term health problems than established treatments such as methotrexate.

As rheumatoid arthritis requires lifelong treatment, it is important to understand how the newer drugs compare to other treatment options in terms of side effects when used for a period of many years.

All of these drugs have been tested in clinical trials and approved for use but more information is needed. The reasons for this are (i) clinical trials run for a short period of time (weeks/months), (ii) have fewer numbers of participants compared to those who will ultimately be treated with the drug in the NHS and (iii) may exclude participants with additional diseases (comorbidities). Therefore, we especially need more information on the side effects of these drugs prescribed in NHS rheumatology clinics over a long period.

The study therefore involves following up patients who are taking a number of different drugs for rheumatoid arthritis. The study team will observe the frequency with which long-term side effects occur in patients receiving the newer treatments compared to those taking established treatments.

In 2021/22 6 new patients were recruited to this study

**Project 2: Methotrexate use Improvement in Rheumatoid Arthritis using Biomarker Feedback (MIRA): A Feasibility Trial**

To assess the feasibility of a randomized controlled trial of a High Performance Liquid Chromatography-Selected Reaction Monitoring-Mass guided intervention in patients with RA treated with Methotrexate (MTX). There is a need to measure adherence directly to facilitate more precise and objective measurements of adherence to add to the clinicians tools to detect non-adherence and help to open up honest discussions and supportive interventions with patients. Such a direct method of biochemical screening for non-adherence is likely to involve the detection of MTX itself or a metabolite.

Non-adherence to MTX is associated with reduced response, increased healthcare costs to the NHS and reduced quality of life for the patient. Failure of MTX and a further disease modifying anti rheumatic drugs to control disease makes patients eligible to receive more therapy, but it is not known whether non-response to therapy, in a subset of patients, is due to non-adherence to MTX.

Recruitment commenced 4th June 2020 and was then suspended due to COVID- 19. We were able to offer follow-up visits and consultant contact with the patients already on the trial. Recruitment re-commenced in March 2021.

**Project 3 Falls & Fragility Fracture Audit programme –**

It has been known for several years that to set up a service which screens patients, over 55 years, who have suffered a low trauma fracture (defined as a fracture from a fall from standing height or less) and treating those patients who have osteoporosis can prevent up to 50% of hip fractures over the following 5 years. This could save the NHS many millions of pounds a year as well as reduce the pain and disability associated with fractures. A framework for FLS has been developed by the National Osteoporosis Society and is subject to national audit. Participation in this audit project has involved working with our local acute trust to establish mechanisms for data sharing and capture. There is a significant amount of additional data capture, cleaning and entry onto the system over and above routine clinical care.

The aim is to understand the variations from the national standard and react to any identified deviations to normal practice to ensure we consistently meet the standard

We have monitored our results with the national standards and made changes to ensure a more streamlined and timely pathway for the patient. We continued with the identification throughout Covid-19 and data entry, but DEXA service was suspended so investigation paused in April 2020, but a log maintained for when it recommenced. The service became fully operational again in August of 2020.

Patient attending casualties with fractures are treated by usually junior orthopaedic staff in busy fracture clinics. It is not possible, nor or those staff training to carry out a robust assessment for osteoporosis. A bespoke FLS service is needed to carry out this function

**Project 5: National Early Inflammatory Arthritis Audit**

National Early Inflammatory Arthritis Audit is national audit for all patients seen in specialist rheumatology departments with suspected inflammatory arthritis. Information will be gathered over the first 12 months of specialist care for all patients diagnosed with inflammatory arthritis.

The aim is to improve the quality of care for people living with inflammatory arthritis by assessing the performance of rheumatology units across England and Wales against NICE Quality Standards.

Information is entered in a national database including waiting times; time to treatment; clinical response to treatment; provision of education and patient reported outcomes.

**Project 6: Carpal Tunnel Surgery Audit**

Carpal tunnel surgery is performed on those requiring and meeting the EUR criteria. To ensure the correct patients are being referred for surgery we undertake the Boston hand score (PROM) pre and post-surgery to assess response.

To ensure those that would benefit most are receiving surgery and achieving an adequate outcome.

Data is analysed and reported back quarterly to the SLT and adherence to EUR analysed, allowing necessary changes to be implemented.

The aim is to inform day to day practices and continually assess effective use of resources This service is currently paused whilst we assess the most appropriate staffing requirements but aim to re start this as soon as possible.

**Project 7: Persistent Pain Service audit**

The persistent pain service offers a comprehensive persistent pain model and is delivered by a multidisciplinary team. Each quarter, patients PSEQfrom referral and discharge are compared, alongside the CGI-improvement score to ensure the service is having an impact on the patient pain and activity levels

A quarterly audit and review allow the SLT see the impact on patient’s pain and activity levels and make any necessary changes to improve any areas that require development within the pain service to achieve maximum impact on the patient.

A summary of the outcomes is provided below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **OUTCOME MEASURES** | **APR-JUN 2021** | **JUL -SEPT 2021** | **OCT TO DEC 2021** | **JAN TO MAR 2022** |
| Mean improvement in PSEQ | 11.2 | 13.4 | 15 | 11.9 |
| Median improvement in PSEQ | 8 | 14 | 13.5 | 11 |
| Range of improvement in PSEQ | (-14 - 53) 67 | (-40 - 47) 87 | (-10 - 40) 50 | (-11 - 39) 51 |
| % of patients showing no improvement or deterioration in PSEQ | 23/75 30% | 18/94 (19%) | 32% | (17/70) 24% |
| (Number) and % of patients who showed some improvement in PSEQ | (52) 70% | (76/94) 81% | (40/59) 68% | (53/70) 76% |
| (n) and percentage of patients who showed clinically significant improvement in PSEQ( Improvement of 8 or more in PSEQ used to calculate clinically significant) | 39 (52%) | (68/94) 72% | (28/59) 47% | (42/70) 60% |
| Mean change in CGI | 2.6 | 2.3 | 2.6 | 2.3 |
| Median change in CGI | 2 | 2 | 2 | 2 |
| Range of improvement in CGI | (1-6) 5 | (1-7) 6 | (1-7) 6 | (1-7) 6 |
| % of patients showing no improvement or deterioration in CGI | (24/87) 26% | (14/118) 12% | (20/70) 29% | (17/95) 18% |
| (n) and % of patients who showed some improvement in CGI | (63) 73% | (99/118) 84% | (50) 71% | (78/95) 82% |
| (n) and % of patients who showed much/very much improvement in CGI ( score of 1 or 2) | 48 (55%) | (65/118) 55% | (36) 51% | (59/95) 62% |
| CGI no improvement 4, 5 or 6 | (24) 16% | (19/118) 16% | (20) 29% | (17/95) 18% |
| Number of patients who showed no improvement in both PSEQ and CGI at discharge | (22) 25% | (6/94) 6% | (10) 18% | (5/67) 7% |

**Project 8: Versus Arthritis MSK Champions Programme- Leadership in MSK Care**

Dave Pilbury was in the first cohort of the MSK Champions Leadership programme for Versus Arthritis based at Hult International Business school.  This illustrious programme joins together clinicians across the fields of MSK and Rheumatology.

Various projects across the Champions programme including development of First Contact Practitioner education, Decision Support Tools for Hip, KNee, Back and Shoulder pain, Pool based supported exercise programmes, community developed pain support groups.  It also feeds into the Best MSK Programme for NHSE as well as the development of the new MSK national dataset.

Dave's involvement in this programme will continue indefinitely and he is a mentor on the new British Society of Rheumatology programme for developing leaders in Rheumatology.

**Project 9. Versus Arthritis (VA) Development of Decision Support Tools in MSK Care for NHS England**

The MSK Decision Support Tools were created in 2020 after being commissioned by NHSE.  They are free to use and downloaded from the NICE and Versus Arthritis websites.  Dave Pilbury's role is to update them each year ensuring they follow up to date guidance which is published each year.

The tools are to target consistency across services with health literate information available to all to aid patients decisions about their care.  This project will continue until 2025.

**The following schemes commenced during 2021/2022**

**Project 10. BIOTIPRA/BRAGGS**

This study will examine the drug levels and antibodies of patients commenced on the drug Amgevita with the results being fed back to clinicians to assist in making informed Treatment decisions. As BIOTIPRA is a sub study of BRAGGS we will also be recruiting patients to BRAGGS study.

This study collects data from patients treated with biologic therapy to evaluate the role of the genetic variation, psychological status, clinical variables, serological measures and environmental factors in determining response to treatment.

**Project 11. Manchester Digital Pain Manikin (MDPM)**

This project was a feasibility study to test a new pain self-reporting tool. The MDPM app supports people across ethnic backgrounds with musculoskeletal conditions to report their pain quickly and accurately on their smartphone,using the app to daily self-report their pain for one month. The study recruited 19 participants. The results from the study are currently being analysed.

**2.6 Statements from the CQC**

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

In March 2022 we had a full inspection from the CQC which led to an overall rating of Good for the service. We were particularly proud that in the domain of well-led we received a rating of Outstanding.

**The key findings from the inspection were:**

• There were systems and processes in place to safeguard patients from abuse and staff were able to access relevant training to keep patients safe.

• The service learned and made improvements when things went wrong.

• Regular and ongoing training was provided to ensure staff were suitably qualified for their role.

• Staff worked together and worked well with other organisations to deliver effective care and treatment.

• Staff treated patients with kindness, respect and compassion.

• Staff helped patients to be involved in decisions about care and treatment.

• The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

• Leaders had the capacity and skills to deliver high-quality, sustainable care.

• Structures, processes and systems to support good governance and management were clearly set out, understood and effective.

• There were clear and effective processes for managing risks, issues and performance.

We saw the following outstanding practice:

Leaders consistently demonstrated a commitment to best practice performance and risk management systems to ensure staff had the capacity and skills to deliver high quality sustainable care.

There were systems in place to review all aspects of the service for ongoing improvement with identified problems being addressed quickly and openly.

There were systems to support improvement and innovative work, such as:

• There was a detailed and ongoing programme of clinical audit. This work linked to National audits and those carried out within the organisation.

• The provider was involved in ongoing research and worked closely with both Newcastle and Southampton University.

• The clinical team were involved in developing various health-related Apps for people across ethnic backgrounds.

• Systems and processes were proactively analysed and reviewed with time set aside to reflect on best practice.

• Significant events were carefully monitored with working parties set up to analyse information in detail to find solutions to ensure improvements.

This has resulted in Pennine MSK providing a high quality service that was well led and responsive to patients changing care needs.

Overall summary

**2.7 Safeguarding Statement**

We are committed to safeguarding and promoting the welfare of adults, children and young people and to protect them from the risks of harm. We promote a ‘Think Family’ approach.

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

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

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

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

This is included in induction and repeated at regular intervals via our mandatory training schedule.

Staff complete Prevent training at Induction and every 3 years.

Learning from North West Region safeguarding newsletters and alerts is shared regularly with staff via operational updates and also discussed with staff at Clinical Peer Review.

The safeguarding lead has undertaken level 3 training.

**2.8 Data Quality**

This is a rolling programme with submissions of information during 2021/22 to the Secondary Users Service (SUS) for inclusion in the Hospital Episodes Statistics which are included in the latest published data.

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

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

**2.9 GDPR and Data Protection Toolkit attainment**

We have again achieved all standards for the Data Security and Protection Toolkit.

Our Information Governance Board meet quarterly to address any issues and to ensure we maintain compliance.

**2.10 Highlights of initiatives to improve service user experience and feedback**

**CSE -** ( as detailed at 1.3)

**Rightpath**

The RightPath model of Innovating for Improvement Musculoskeletal triage service for children and young peoplehas now been commissioned. Using the Rightpath model, we have now successfully and reliably triaged referrals for over 2,000 children and young people.

This is now embedded into routine service delivery and we have developed similar triage guidance for adults, ‘Navigate’ which aims to ensure that patients see the right person the first time.

**Part 3**

**3.1 Review of quality performance**

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

We achieved all of our Key Performance Indicators and our achievements against a selection of our main ones are provided;

* **Referral to Treatment (RTT)** - We have a target to treat 95% of patients within 18 weeks from referral. We have achieved 98% during 2021/2022
* **Diagnostic Waiting Times** - We are challenged with ensuring that patients wait less than 6 weeks from referral for a diagnostic test. This has been greatly affected by staff shortages relating to the pandemic in the radiology department. This slowly improved over the year and we continue to work with our partners in radiology to reduce the waiting times for patients.
* **Appointment waiting times**–these have been affected by the COVID 19 but these have much improved since the introduction of more clinics. We saw 100% of all urgent referrals within 2 weeks of receiving the referral and we saw 90% of routine referrals within 4 weeks.
* **Patient satisfaction score using the friends and family test**
* **All patients are treated, discharged or onward referred within six weeks –** 97% of our patients are seen treated or discharged within 6 weeks.
* **We are targeted to cancel no more than 3% for appointments within 5 days –** last year we achieved 0.75%
* **Patient satisfaction score using the friends and family test -** This is measured using the Friends & Family Test (FFT). The FFT has been rolled out to all patients during the year.

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

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

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

To date our average score for this test is 94% positive meaning that 94% of patients who completed the Friends and Family Test scored ‘extremely likely’ or ‘likely’ to this question.

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

**Everything was perfect- 5 star service from the team. Thank you so much**

**Had excellent treatment, very kind, very helpful, understood my health problems, msk have been supporting and treating my RA for last 12years, cant thank them enough for all their kindness, care, and professional treatment Ive received from them all. Always there when I need help or advice. Thanks to all of the msk team for looking after me**

**Excellent experience. Knowledgeable friendly podiatrist who put me at ease and fully explained things to me.**

**Doctor very attentive in her examination and was clear about my future medication practice routine. Blood test carried out professionally and X-ray undertaken without delay**

**All Covid regulations are in place and working well. All staff from entry to exit are professional, efficient, helpful and pleasant. I was apprehensive but had no need to worry. Well done and thank you**

**Appendix 1**

**Glossary of Terms**

**Virtual Consultant Clinics**

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

**Care Quality Commission**

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

**Clinical Audit**

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