

NHS Wales Executive - Service Specification

Integrated Service for Musculoskeletal Health

Document Information	
Document Purpose	Service Specification
Document Name	Specification for an integrated primary and community care musculoskeletal health service
Author	The Strategic Clinical Network for MSK Health, on behalf of NHS Performance and Improvement
Publication Date	
Version	0.6
Target Audience	Chief Executives, Medical Directors, Directors of Finance, Directors of Nursing, Chief Operating Officers, Directors of Planning, Directors of Allied Health Professionals and Health Sciences, Directors of Primary Care
Description	NHS Wales Health Boards will routinely provide this service in accordance with the criteria described in this specification
Review Date	Formal review of the document will be one year after publication Review of the service will be ongoing through the peer review process administered by the Strategic Clinical Network for MSK Health

Revision History		
Revision Date	Group/Organisation	Version
Feb 2025	Initial draft out to CRG	Draft 0.1
April 2025	Draft edited considering initial comments received from MSK CRG and in light of the recently approved critical care Service spec.	Draft 0.2
June 2025	Draft edited in light of feedback from CRG members and WON	Draft 0.3
June 2025	Draft edited in light of feedback from WON	Draft 0.4
July 2025	Draft edited to present to CRG in August	Draft 0.5
Sept 2026	Draft edited following further comments from CRG members	Draft 0.6

Endorsements		
Approval Date	Group/Organisation	Version
	MSK CRG – prevent, diagnose and treat	
	SPPC directors’ group	
	Primary care cluster leads peer group	
	DAHPS peer group	
	AWMD’s peer group	
	DOP peer group	
	COO peer group	
	Strategic Clinical Network MSK Health Clinical leadership group	
	National Clinical framework implementation Board	

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Useful Abbreviations

WHC	Welsh Health Circular
NICE	National Institute of Health and Care Excellence
PROM	Patient Reported Outcome Measure
PREM	Patient Reported Experience Measure
IMTP	Integrated Medium Term Plan
CPD	Continuous Professional Development
CRG	Clinical Reference Group
CIN	Clinical Implementation Network
KPI	Key Performance Indicator
PADR	Personal and Development Reviews
MSK	Musculoskeletal
GMS	General Medical Services
PCMW	Primary Care Model for Wales
MDT	Multidisciplinary Team
QI	Quality Improvement
WON	Wales Orthopaedic Network
SWSN	South Wales Spinal Network
NCF	National Clinical Framework
DNA	Did Not Attend
CNA	Could Not Attend

Glossary of Terms

Employ to Deploy Model	An employment and governance model under which Health Boards employ clinical staff to be deployed within practice, cluster or pan cluster primary care teams, that is recommended in the Primary and Community Care AHP workforce guidance .
Handover	The transfer of information and of professional responsibility and accountability for some or all aspects of care for a patient, or group of

	patients, to another person or professional group on a temporary or permanent basis
Referral	Referral refers to the process of directing a patient from one healthcare practitioner to another, usually a specialist or a healthcare facility with specific expertise. Referrals are made when the patient's needs go beyond the capabilities of the initial healthcare provider.
GMS Contract	A General Medical Services (GMS) contract is the standard, nationally negotiated agreement in Wales for GP practices to deliver core primary care services for the NHS.
Community by Design	A planning approach to transform the delivery of care through fully integrated systems thinking. The aim of the approach is to deliver services effectively and safely in the community and consider what system adjustments are needed, at local partnership and national levels, to drive such an ambition. This approach is grounded in ensuring that all resources along a health pathway should be directed towards to best outcomes and experience for service users.
Undifferentiated Symptoms	Signs and symptoms that are present but not specific or severe enough to fit the criteria for a single, well-defined diagnosis.
The Service	All mentions of 'the service' are in reference to the proposed new integrated MSK service.
Subspecialty Interface Service	A coordinated approach to multidisciplinary working and communication at the point of crossover between the Integrated MSK service and a specific medical or surgical subspecialty.

Statement

This document has been developed to inform the provision of an integrated service for individuals at risk of or experiencing musculoskeletal health (MSK) conditions. In creating this document, the Strategic Clinical Network for MSK Health has reviewed the requirements and standards of care that are expected to deliver this service. Further work is ongoing to establish the national level of need and capacity in collaboration with health boards.

Disclaimer

The Strategic Clinical Network for MSK Health and NHS Wales Performance and Improvement assume that healthcare professionals will use their clinical judgement, knowledge and expertise when deciding whether it is appropriate to apply this specification.

This document may not be clinically appropriate for use in all situations and does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual, in consultation with the individual and/or their carer or guardian where appropriate.

The Strategic Clinical Network for MSK Health and NHS Performance and Improvement disclaim any responsibility for damages arising out of the use or non-use of this specification.

1. Introduction

1.1 Background

Policy and Framework

In response to the rising incidence and impact of Musculoskeletal conditions, both globally and within Wales, the Welsh government have published a [Quality Statement for MSK Health](#). In response the NHS Wales Performance and Improvement have launched a [Strategic Clinical Network for MSK Health](#) which is leading a collaborative and co-produced quality improvement approach under the recently published ["living with Arthritis and Musculoskeletal Condition in Wales: A framework for the future 2024 -2029"](#). This service specification should be read and applied alongside these documents. Together these documents describe the need to prioritise robust and sustainable primary and community care services for individuals, at risk of, or living with MSK conditions. They also articulate the principles that should be followed to align with the five goals of the [Planned Care Programme](#) and [6 Goals for Urgent and Emergency Care](#).

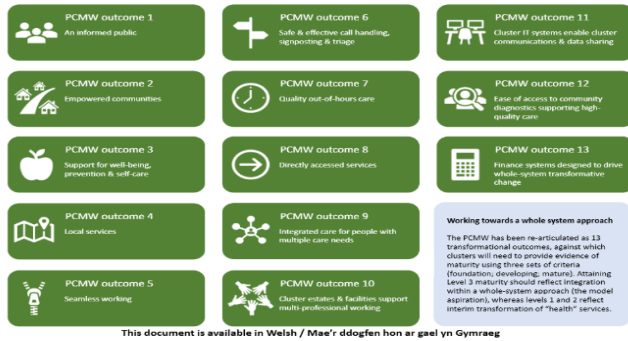
Delivering on the Quality Statement and Framework will require a shift to greater collaboration and multiprofessional services, delivering within the primary and community care space whilst integrating with hospital-based services.

The Strategic Programme for Primary Care has developed tools that will enable delivery. Explicitly, the [Primary Care Model for Wales](#) contains [13 key components](#). Furthermore, the [Accelerated Cluster Development \(ACD\) Programme](#) contains [Professional Collaboratives](#) and [Pan Cluster Planning Groups](#) to strengthen multi-professional working in place-based care. These groups will be key collaborators to make this specification a reality.



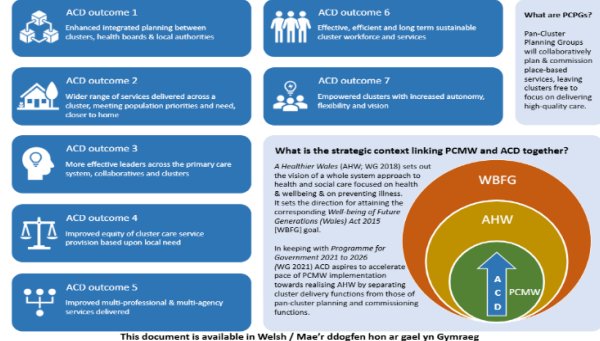
PCMW | PRIMARY CARE MODEL FOR WALES

Describes how care will be delivered locally, now & in the future, as part of a whole system approach to deliver A Healthier Wales



ACD | ACCELERATED CLUSTER DEVELOPMENT

ACD's overarching aim is to meet cluster population health need through effective & robust planning & service delivery



Existing Services

General medical services (general practice) and urgent care services are the default first point of contact for the NHS. Specialty services for individuals with MSK conditions that currently sit in the primary and community care space have grown mostly organically and locally, without national guidance. Three types of service have emerged, with high variation in the connectedness between them.

- Therapy led rehabilitation services, have become known as “core” or “mainstream” service and focus on the person-centred rehabilitation and management of individuals with a variety of MSK conditions and co-morbidities. These services frequently enable direct access or self-referral without the need for a healthcare professional referral.
- Triage and treat services emerged during the 2000’s and were formalised under guidance published in 2017 [Establishment of a clinical Musculoskeletal Assessment and Treatment Service \(2017\)](#). This part of the service employs advanced practitioners within MDT’s that support diagnostics and pathway navigation, primarily aimed at the cohort for whom direct referral to Orthopaedics is not recommended.
- The final part of the service follows the initiative in England to employ First Contact Practitioners within a General Medical Services (GMS) environment. Unlike England, the Welsh primary care model supports a more integrated model with employ to deploy by health boards at its core.

This model, with three often separate functions risks isolation of parts of the service, duplication and delay that impacts negatively upon quality. Figure 1 is a graphical representation of the historical model.

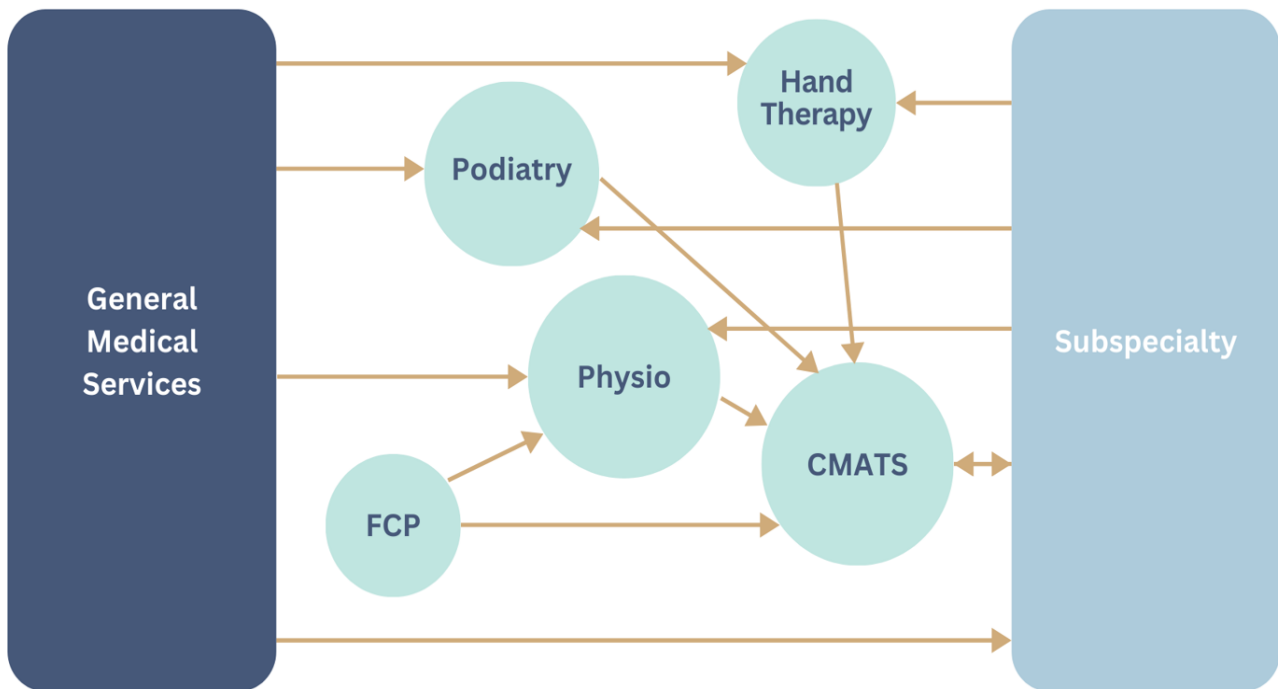


Figure 1: The historical model of how patients flow through MSK services.

In partnership with health boards a baseline understanding of variance and excellence has been compiled, this indicates high levels of variation that are currently not easily understood. This extends across the pathway in the provision of services within GMS, primary and community care and in joining these together the subspecialist services (including persistent pain, rheumatology, orthopaedics and spinal services).

Services are known to be highly variable, including service models, access, governance, and staffing. These current arrangements carry risk of duplication, delay and waste that was highlighted by the Welsh audit office report on [tackling the waiting list backlog in orthopaedic services](#).

The Primary Care Model for Wales (PCMW) calls for a more integrated approach, which this specification describes. The approach integrates the above three services behind one point of access and under one request banner. This enables the team to work collaboratively and to deliver the care that is needed without the additional burden of referrals and waits. It is contingent on team working across professional groups and traditional boundaries. Figure 2 is a graphical representation of the future model.

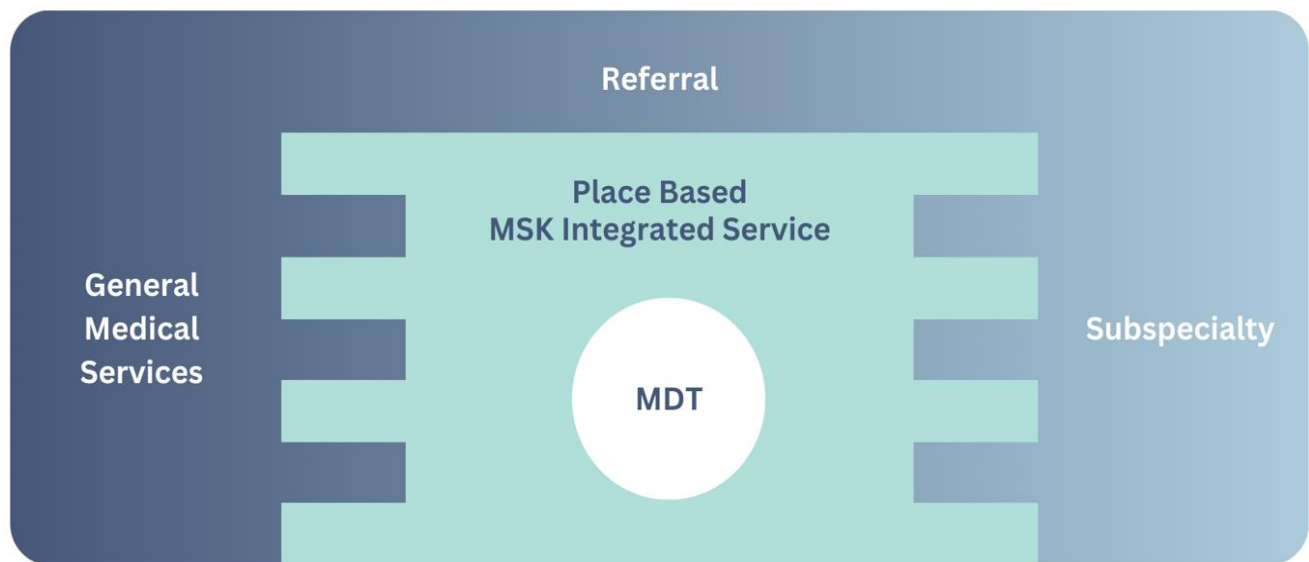


Figure 2: The proposed future model of how patients will flow through MSK services.

There is clinical consensus at the Strategic Clinical Network for MSK Health that a service specification that describes best practices, will assist and guide the quality improvement required by the [National Clinical Framework](#) to best serve local populations. It is expected that integration of the currently available components, into one seamless system would improve value and sustainability, whilst simplifying planning to meet the expected rising population need.

1.2 Scope

In accordance with the National Clinical Framework, this service specification will focus on describing the 'what' (activities and actions) and 'so what' (outcomes), whilst leaving the 'how' (processes and operational arrangements) to be defined in collaborative working with the local delivery teams. This specification should be read in conjunction with the [Quality statement](#) and [Framework](#).

The scope will include all services specialising in MSK conditions that are outside of the GMS contract and are not under the leadership of a subspecialty planned care medical or surgical team. In current language this includes all MSK first contact practitioner (FCP) services, all MSK core/mainstream therapies, all MSK assessment and treatment teams (Clinical Musculoskeletal Assessment and Treatment Service (CMATS), and emerging community models for MSK related persistent pain. This will include a variety of professional backgrounds including general medical, occupational therapy, physiotherapy, podiatry, psychology, pharmacy and sports and exercise medicine.

There is an expectation that integrated MSK services will work collaboratively and in partnership with third sector and community providers to deliver the care that is required at the highest possible value.

This specification does not include subspecialty services, who will have direct referral from GMS in alignment with nationally agreed pathways of care. For instance, suspected early inflammatory arthritis is seen directly by rheumatology in early inflammatory arthritis clinics. Subspecialty MSK AHPP clinicians working within these environments should be affiliated to the integrated MSK service described here under an “employ to deploy” model, this will ensure full integration and communication between MDT’s across the pathway.

This service specification is owned by the Prevention, Early Diagnosis and Treatment Clinical Reference Group (CRG), within the Strategic Clinical Network for MSK Health. The CRG have co-created and agreed this service specification, with all parts of the Strategic Clinical Network for MSK Health and other key stakeholders across the primary and community care setting. The CRG’s representatives from across the whole system will work alongside delivery teams to implement it. They will create a community of practice that will share good practice and learning in a process of continuous quality improvement (QI). The specification will be reviewed considering the QI processes and amended at appropriate intervals, initially at 12 months, then subsequently every 24 months as a minimum. In order to avoid unwarranted variation and to add value and pace to implementation a series of toolkits will be co-developed and included as an annex.

This document includes an optimisation framework to enable services to assess and monitor progress towards the specification. Progress in implementation and delivery of this service specification will be reported via performance and assurance to the MSK Prevent, Diagnose and Treat Clinical Reference Group, the Clinical Leadership Group of the MSK Strategic Clinical Network and when necessary to the National Clinical Framework Oversight Board.

1.3 Aims

The aims of this specification are to:

- Participate in the creation of a Healthier Wales through reducing the impact of musculoskeletal conditions and inactivity.
- Improve the health and wellbeing of those affected by MSK conditions.
- Where possible prevent disease and disability and reduce the future need for healthcare.
- Set a clear standard for provision of MSK health services for the people of Wales.

- Focus on continuous improvement aligned to improving quality as defined by the Quality Statement for MSK and the Duty of Quality.
- Ensure alignment with the Primary Care Model for Wales and integration with the Strategic Programme for Primary Care, Accelerated Cluster Development Programme, Urgent and Emergency Care Programme and the Planned Care Programme.
- Simplify the pathway and reduce duplication and delay, through an integrated seamless and place-based system that delivers person-centred care in the fewest steps possible.
- Integrate services to wrap the appropriate support around the individual to meet their need in managing a MSK condition in association with common co-morbidities, causative and risk factors.
- Deliver nationally agreed and localised pathways of care built on best evidence, national clinical guidelines and current clinical consensus.
- Create a sustainable shift towards prevention-based health and care and a population health approach, that includes methods to develop capability, opportunity and motivation for health behaviour change, enabling a reduction in demand over the long-term and a sustainable service into the future.
- Facilitate opportunities for greater use, integration and signposting to third sector services, information and support.
- Ensure services deliver early diagnosis, proactive early interventions and support individuals with MSK conditions to be better informed about their condition, treatment and self-management options and decisions about their care.
- Deliver flexible, responsive services and support that respond quickly to the fluctuating and unpredictable nature of MSK conditions.
- Support both the physical and mental health of individuals living with MSK conditions.

1.4 Relationship with other Documents

This document should be read in conjunction with the following documents:

- [A Healthier Wales: long-term plan for health and care in Wales.](#)
- [National Clinical Framework: A learning health and care system](#)
- [Quality and Safety Framework](#)
- [Transition and handover from children's to adult health services GOV.WALES](#)
- [All Wales Rehabilitation Framework: Principles to achieve a person-centred value-based approach \(2022\)](#)
- [All Wales Community Rehabilitation standards](#)
- [Prevention based health and care framework](#)
- [Quality statement for MSK Health](#)

- [Living with Arthritis and MSK conditions in Wales: A framework for the future 2024-2029](#)
- [National Clinical Strategy for Orthopaedic Services blueprint and annex documents](#)
- [South Wales Spinal Network pathways and guidance documents](#)
- [National Institute for Clinical Excellence \(NICE\) guidance and Quality standards in relation to MSK Health](#)
- [GIRFT further faster community MSK Handbook](#)
- [Living with persistent pain in Wales](#)
- [Primary and community care Capability framework for MSK](#)
- [Strategic workforce plan for primary care](#)

2. Integrated MSK Service Model

2.1 Quality Statement – Aim of the Service

The aims of the integrated MSK service are to provide equitable, safe, timely effective, efficient, equitable and patient-centred, care:

- To provide patient centred holistic care that improves quality of life for individuals living with MSK conditions and limits the impact of their condition.
- To support individuals living with MSK conditions to be better informed about their condition, treatment and self-management/self-care options and decisions about their care.
- To improve functionality and increase the quality of life for individuals with MSK conditions.
- To ensure equity of access, equitable care and timely access to MSK services. To work with and signpost to other services that can help individuals to live well with MSK conditions, including employment services, independence supporting services and information and peer support services.
- To reinforce the role played by MSK services to prevent disability and improve quality of life.
- To promote preventative measures to reduce future prevalence and impact of MSK conditions.
- To continue the culture of continual quality improvement underpinned by reliable information and audit.
- To deliver a national performance management dashboard to inform the clinical effectiveness debate at local, network and national levels.
- To participate in national audits and continuous improvement.

2.2 Prevention Based Healthcare

Aligned to the Prevention Based Health and Care Framework, the service specification will enable the delivery of appropriate and prudent assessment of needs and timely access to appropriate intervention to meet that need, across the three tiers of prevention.

Primary prevention – Interventions that build resilience, support well-being or prevent the onset or development of health-related harms/risks, which would potentially lead to poor health outcomes and the need for care e.g., immunisations, enabling people to have warmer homes. Where a local need is identified e.g., lower than expected referral rates, integrated MSK services should outreach and intervene with communities and groups at high risk of developing MSK conditions.

Secondary prevention – Interventions that lead to the early identification of needs or conditions. These may be targeted towards those with a condition or risk factors, which can then be addressed, thereby reducing their potential effect on health and wellbeing outcomes e.g., early identification and management of high blood pressure; falls prevention interventions. Integrated MSK services should prioritise secondary prevention activities at the earliest part of the pathway to prevent disease progression and disability. This will require the development of skills in assessing risk factors, communicating their importance, generating opportunities for change and supporting individuals appropriately. Appropriate linkage with medical services will be required to address modifiable and optimisable risk factors such as BMI and HbA1c

Tertiary prevention – Interventions that mitigate problems once they have occurred. This includes delaying the course of established conditions and/or supporting individuals to regain skills and independence to reduce their level of need, to minimise poor health outcomes e.g., high quality delivery of care processes in the management of diabetes; rehabilitation/reablement services; respite care. Integrated MSK services should prioritise the use of established best practice interventions for the management of established MSK conditions, aligned to the [rehabilitation framework](#) and community health pathways. Integrated MSK services should work collaboratively with subspecialist services to apply pathway guidance to provide timely access to high value subspeciality services for both diagnosis and intervention.

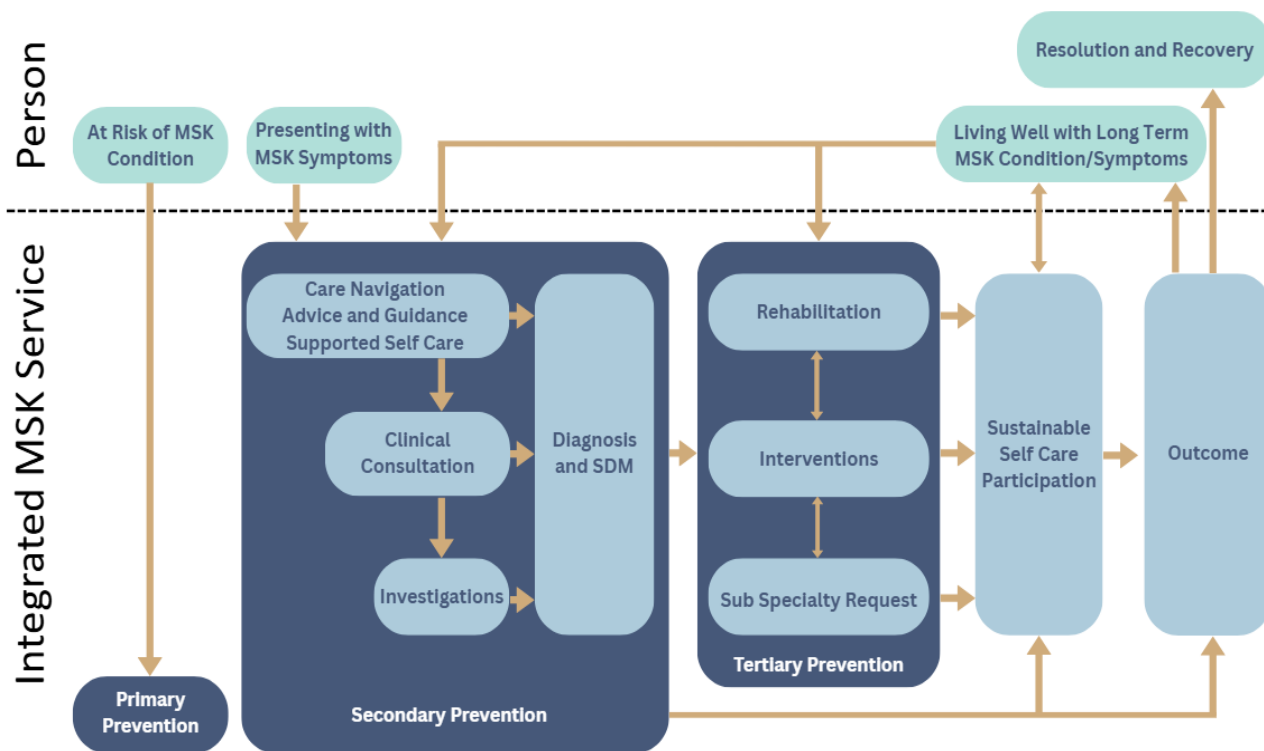


Figure 3: Prevention based healthcare delivery through an integrated MSK service.

2.3 Core Principles

- Integrated MSK services should create and maintain a Local Needs Analysis that provides an understanding of local population needs and priorities in respect of MSK conditions. This should include local stakeholder maps to understand local resources and capabilities and be aligned to the local authority needs assessment.
- Integrated MSK services should be accessible by multiple routes that meet the local population needs. This should include both self-initiated and healthcare-initiated requests.
- Self-initiated requests should not be considered as a replacement for the role of GMS services in undifferentiated symptom presentations. GMS will continue to be an important part of the MSK pathway, differentiating conditions and providing management prior to requests for help from an integrated MSK service.
- In order to reduce inequity and unexplained variation, whilst maintaining a learning environment and feedback to referrers, all requests should go through a “single point of access”. The single point of access refers to an equitable process where clinical condition codes and criteria agreed at national networks are applied within established pathways consistently by

all teams and individual clinicians in the MSK pathway (integrated MSK service and all subspecialty teams). Individuals will be allocated to the agreed and appropriate clinician at the appropriate time and place to meet the individual needs.

- Requests should fall into one of three categories:
 - Request for a well-defined community rehabilitation intervention on a specific pathway. This occurs when a professional is confident in the diagnosis and has reached a shared decision that the individual wishes to participate in the intervention e.g., ESCAPE Pain or Good Boost.
 - Request for diagnostic and management opinion. This occurs when a professional is not confident in the diagnosis or shared decision making for this presentation and asks the service to provide an opinion and complete the pathway navigation.
 - Request for management opinion. This occurs when a professional is confident in the diagnosis but not confident in the shared decision making for this presentation so asks the service to provide an opinion and complete the pathway navigation.
- Requests to the integrated MSK service are stratified on the basis of need. Initially this will include all clinical information provided on the request (including biomedical red flags) and reasonable requests for further information from referrer or individual.
- Urgent care (within 10 working days) should be given to individuals who meet the following criteria:
 - Individuals who have had recent surgery/procedure, requiring rehabilitation; and/or
 - Individuals who have had recent injury, fracture or dislocation requiring rehabilitation; and/or
 - Individuals with acute and/or complex needs with high levels of pain (such as acute back pain), leading to significant loss of function and/or disturbed sleep and an inability to work or undertake care responsibilities
- All providers should develop methods to include assessments of individual need (e.g., [MSK-HQ](#)) and capability (e.g., using an activation or empowerment measure and START MSK, START BACK or Orebro).
- All requests should be allocated a condition code at the earliest opportunity in the pathway and these codes should be updated as diagnostic processes are completed. The condition coding will be developed nationally, in co-production with subspecialist and GMS stakeholders and aligned to best

practice pathways. They will enable tracking through the system and be major source of data for quality improvement.

- All requests will be allocated to a pathway that facilitates a level of care matched to the identified need, for instance:
 - Those with low risk of chronicity, low impact and high activation – should be supported to self-manage.
 - Those with low risk of chronicity, low impact and low activation – should be assessed and, where appropriate, supported to self-manage
 - Those with high risk of chronicity should be assessed and supported appropriately on a pathway that leads to supported self-management

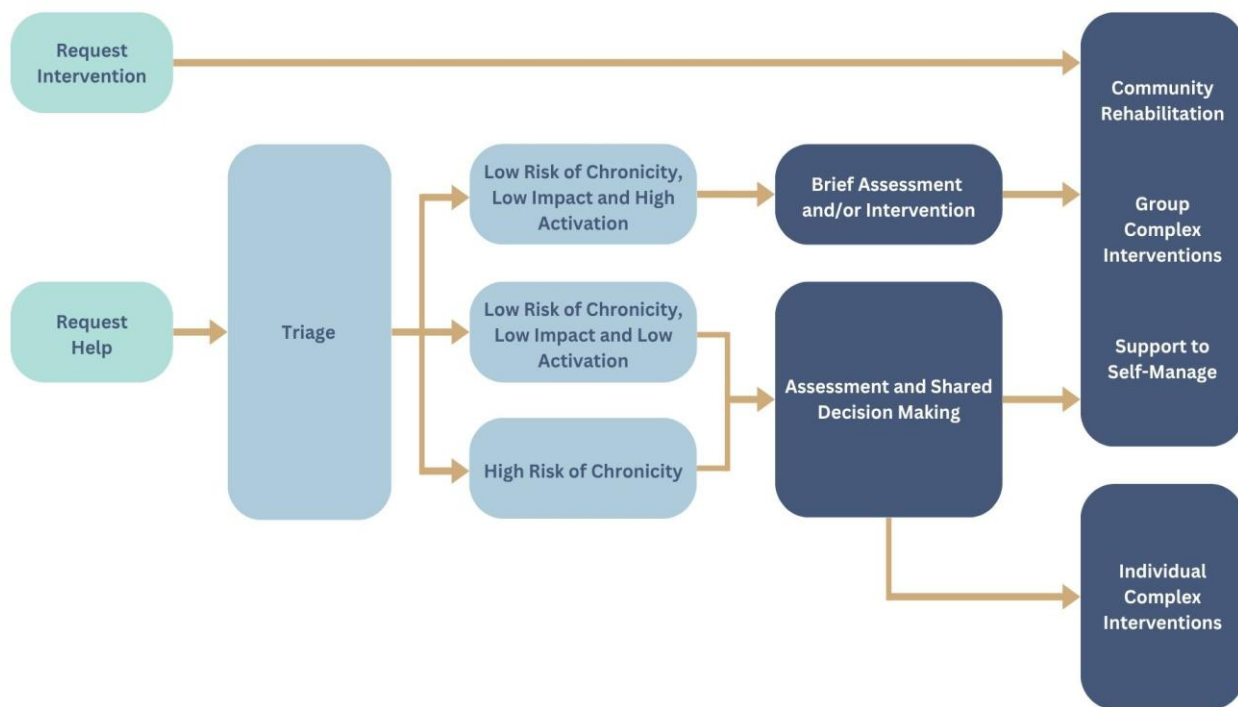


Figure 4: The pathway through the integrated MSK service, based on need.

- Pathway allocation will be completed within appropriate timescales; 24 hours for urgent requests and 3 working days for routine requests.
- Requests should be accepted from any professional working within the GMS MDT, urgent primary care centres, minor injury units, emergency departments, 111 and subspecialist secondary care teams.
- All requestors are expected to move to electronic referral systems. Clinical referrals should be made using Welsh Clinical Communities Gateway (WCCG) and Welsh Admin Portal (WAP) in line with health board plans for implementation.

- Urgent care needs should be met within timescale agreed on the national pathways; in most cases this will be within 10 working days of accepting the request. This should be facilitated with direct access walk in, and/or public facing scheduling tools.
- Routine care needs should be met within timescales agreed on national pathways and/or nationally set referral to treatment targets. There will be a considerable transition period where this and other guidance will impact both demand and capacity. Health boards should make decisions based on value, risk and system impacts when distributing resources and should be supported with a relaxation of waiting time targets during this period. Performance and assurance of waiting times should be considered across the system and MSK pathway so that large improvements in some services are not overshadowed by smaller deterioration elsewhere.
- The integrated MSK service will have direct access to diagnostics (radiology, haematology, nerve conduction studies and biochemistry) which is fully aligned to the nationally agreed pathways of care. A national scope will be developed to support equitable implementation across provider organisations.
- The integrated MSK service will promote prevention and supported self-management to give individuals the tools and confidence to self-manage symptoms and modify risk factors in the long term.
- The integrated MSK service shall ensure individuals have appropriate advice and support to enhance shared decision making about their future treatments and care. Where available this should make use of approved national documents aligned to community health pathways.
- The integrated MSK service shall ensure that individual holistic needs, including biological, psychological and social factors are considered, and information, advice and support is available in a way that is accessible to the individual.
- Simple presentations should be allocated to junior staff at AFC bands 5 and 6 whilst more complex presentations should be allocated to senior staff at band 7 and above.

Examples

<i>To be included in final version</i>
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- There will be a mechanism for escalation of care to senior staff within the service (without the need for a referral and associated delay).

Examples

To be included in final version

- There will be a mechanism for escalation to affiliated multiprofessional subspecialty teams (including persistent pain, orthopaedics, rheumatology and spines) as deemed appropriate and in line with national and local pathways. Guidance to support this is currently available from the south Wales spinal network (CP01 –elective surgical spinal pathway) and will be developed and published in co-production with the Wales Orthopaedic Network (WON) subspecialty CRG's.
- Requests for access to subspecialist pathways should follow one of two routes aligned with national pathways and condition codes:
 - Where pathways and criteria can be clearly defined requests should be managed by onward referral following the appropriate pathway and including the defined referral criteria and data set.
 - Where pathways and criteria are less easily defined a MDT hand over at a "subspecialty interface clinic" will enable MDT learning and ensure clinical agreement on those accepted onto subspecialty diagnostic or intervention pathways.
- The subspecialty interface clinic may take several forms in order to provide an appropriate environment for that subspecialty need. Format, inclusion criteria and processes will be defined in co-production with the relevant WON CRG's and rheumatology CIN's. SWSN CP01, South Wales Spinal Network guidance is the current standard and should be used to inform developments across subspecialities. Virtual and in-person (with the individual) models should be considered to best meet the need. Care should be taken to minimise variation in the model to that which is necessary for the subspecialty requirements. Too many disparate models risk adding confusion and unnecessary complexity to the system. Within the subspecialty interface the scheduling and clinical responsibility remains with the integrated MSK service who are providing the information upon which decisions are being made. All discussions in these clinics should be formally documented in appropriate clinical records.

Examples

To be included in final version

- The subspecialty interface provides an opportunity for wider involvement of members of the integrated MSK team to build relationships and trust at a service level with subspecialty colleagues.
- In order to develop the necessary collaboration, multiprofessional communication methods should be established and utilised to build

relationships and ensure the ability to discuss individual cases in a timely manner.

- The integrated MSK service should be closely integrated with the developing primary and community persistent pain services and align with a service specification due to be published by the Persistent Pain Clinical Implementation Network (CIN) in 2026.
- Understanding that management of MSK conditions is not static and individuals may be at different stages in their own health journey (which frequently involves fluctuations in symptoms and disease activity), the service will provide a person-centred approach, adapted to the needs of the individual. This will require different levels and types of support for different individuals. Engaging with self-management of MSK conditions can be challenging. In association with the multiprofessional team, the service will assess and actively support individuals to manage challenges associated with engaging in supportive treatments and self-management.
- Appropriate See on Symptom (SOS) and Patient Initiated Follow-Up (PIFU) pathways should be established:
 - PIFU is defined as an alternative to routine follow-up in cases where the next appointment does not need to be booked at that point in time as the condition is being managed well by the patient. Therefore, the patient and clinician agree that the patient initiates the next follow up when required, based on their understanding of their condition and when support is needed to maintain their health and wellbeing. This approach is usually used with patients with long-term conditions.
 - SOS is defined as a patient-centred approach that is used as an alternative to routine follow-up which results in patients being discharged when clinically safe to do so and then relies on the patient to self-refer if there are any issues with their condition within an agreed timeframe. See on symptom pathways should be utilised for short-term conditions.

2.4 Team Activities

The team will provide the population that they serve with:

Outreach	To identify and engage marginalised and high-risk groups and those who are disproportionately affected
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	by MSK conditions e.g., those with high level of risk factors.
Co-production	To work across the multiprofessional team, third sector and local community to collaboratively develop service offers in partnership that meet needs across the three tiers of prevention.
Care Navigation	To understand need and direct to the appropriate pathway in as few steps as possible with 'one-stop shop' principles adopted where possible.
Advice and Guidance	To be provided in a way that is accessible to the individual's needs. It should support a holistic approach and include self-management of the condition, symptoms and associated impacts such as employment and independent living.
Employment Support	To support individuals to remain in or return to employment.
Supported Self-Care	To enable self-management of long-term conditions.
Clinical Consultations	To facilitate timely and accurate diagnosis through access to clinical examinations and appropriate investigations.
Person-centred Approach	To include all appropriate elements of the biopsychosocial model and a "what matters to me" approach.
Access to investigations	To be requested appropriately according to pathway guidance and Shared Decision Making (SDM).
Diagnosis	To be communicated in a way the individual can understand and act upon.
Shared Decision Making	To support shared and informed decisions during consultations, care and plan of action going forwards.
Proactive early interventions	To support rapid recovery or management of symptoms.
Rehabilitation Interventions	Providing interventions that are preventative, restorative or supportive
Interventions	Providing evidence-based interventions that are high value and support NICE guidance.
Subspeciality Opinions and Referrals	To be aligned to nationally agreed condition codes and pathways. These opinions will enable an early shared decision before a planned care request.
An Outcome	To provide an outcome which is either: <ul style="list-style-type: none"> • Resolution and recovery from a short term MSK condition <p style="text-align: center;">or</p> <ul style="list-style-type: none"> • Living well with a long term MSK condition

Self-guided Access	To direct to the appropriate part of the pathway for individual needs, including urgent access, SOS and PIFU pathways.
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2.5 Integrated MSK Service - Team Characteristics

Person-centred care requires the participation of a fully staffed, multidisciplinary clinical team. In alignment with the NCF, “clinical” is defined as any stakeholder with an interest in outcomes and therefore includes individuals with lived experience, third sector organisations and local community stakeholders such as leisure, employment and education.

Healthcare professionals within the multidisciplinary team should include sufficient skills across a spectrum of professional groups including dietetic, health coaching, occupational therapy, pharmacy, physiotherapy, podiatry, psychology, medical, and nursing staff at an appropriate mix of grades (such as consultant, advanced, enhanced, graduate, support worker, health coaches, GP, GPwSI and sports and exercise medicine), to meet the local population need. Subspecialty expertise will be required via sessional commitment in areas including radiology, rheumatology, persistent pain, bone health, orthopaedic and spinal surgery, aligned to the local population need.

Currently available professional guidance on appropriate staffing levels is very limited ([CSP MSK service standards](#)) and very old ([CSP recommendations on staffing MSK services 2001](#)). The MSK CRG is in the process of reviewing existing best practice across the UK and will include the resulting recommendations for staffing levels in a toolkit.

The integrated MSK service team should have an appropriate balance between generalist, specialist and subspecialist expertise to meet the needs of the local population aligned to agreed pathways.

Generalist	Has a breadth of capabilities across the MSK pathway and in the management of common co-morbidities and risk factors – could be allied health, nursing or medical
Specialist	Has a breadth of capabilities to manage all MSK presentations and the impacts of common causative and associated symptoms. Can manage all but the most highly complex components of presentations (across the biopsychosocial spectrum) which require MDT subspecialist team input – could be medical, nursing, or allied health.

Subspecialist	Has a depth of capabilities in a subspeciality that is not seen in specialist clinicians, such that they can independently manage the most complex presentations within that subspeciality in affiliation with the appropriate MDT. Can also manage the common causation and associated symptoms in this subspecialist group and will connect the service through to subspeciality services and act as the conduit for fully integrating the service and pathway around the individual - could be allied health, psychology, nursing, medical or surgical.
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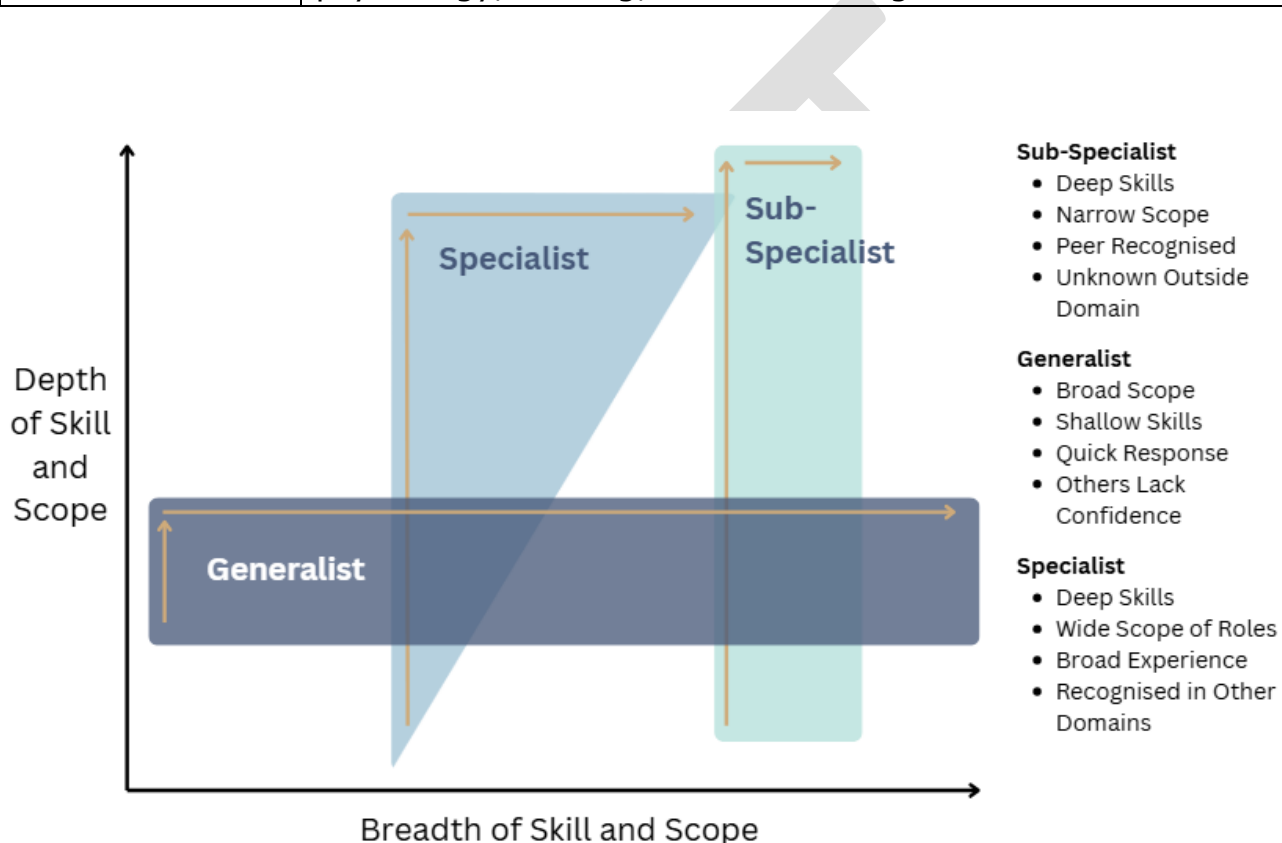


Figure 5: The scope of professional roles and assignments.

- The integrated MSK service will have an appropriately sized administrative and managerial team to manage the administration need of the service and enable clinicians to focus on clinical delivery.
- A multi professional clinical leadership team should consist of both skilled clinicians and managers with postgraduate experience/qualification in the management of MSK conditions and appropriate leadership training and skills to head up this service as defined by advanced and consultant levels of practice. Together they will provide a strong and well-rounded leadership and will be accountable to the health boards MSK Delivery Group, or equivalent.

- The leadership team will be responsible for all quality, safety and patient experience aspects of the service, including CPD and audit. A designated clinical lead should be actively engaged with the Strategic Clinical Network for MSK Health via the prevent, diagnose and treat CRG.
- The integrated MSK service must have a structured learning and development system in place, aligned to the requirements of the [Multiprofessional MSK capability framework for primary care](#) and the [Enhanced advanced and consultant practice framework](#)
- The integrated MSK service will have Personal and Development Reviews (PADR), Continuing Professional Development (CPD) and appraisal monitoring systems in place to promote use of best practice.
- The integrated MSK service must provide an establishment determined by the local population need. A workforce planning toolkit aligned to the rehab demand modelling tool will be co-produced and included as an annex.
- The integrated MSK service must be available for a minimum of 5 days per week, with provision that meets the needs of the working population. It will be available at a quantity and frequency appropriate to meet the clinical needs of the local population within timely care guidelines. There should be links to enable access via out of hours and urgent primary and community care teams.

2.6 Team Locations

Whilst accepting the challenges around estates and facilities, where possible services should be delivered at 'place', preferably within clusters or localities and integrated into community facilities and partnerships where possible. This should be a progressive shift towards [community by design](#), whilst maintaining the team working required to navigate the MSK pathway. Clinicians must not be physically or psychologically isolated from their MDT. Access to services via online and digital methods to meet needs of communities should be considered and adopted.

2.7 Community Rehabilitation/Sustainable Self-Management

Sustainable self-management requires integration with local community facilities and providers, third sector organisations and community partners such as the Education for Patients Programme (EPP) and social prescribing. Where possible, rehabilitation delivery should be fully integrated alongside these sustainable

options to promote sustainable participation and development of local community support.

All integrated MSK services must ensure the provision of rehabilitation services to meet needs in line with the [all Wales Rehabilitation Framework](#) and the [Community rehabilitation best practice standards](#). The rehabilitation framework identifies the requirement for a whole pathway approach, ensuring seamless transition to health board provision and local rehabilitation services. All providers should review existing pathways to ensure the needs can be met within their current location.

All health boards should ensure that they can provide the appropriate support and intervention in a holistic manner with access to all required members of the multi-professional team. Services should be provided in line with the individual's goals and needs. The stepped model of rehabilitation identified in the rehabilitation framework should be used by all health boards. Access to rehabilitation should be determined by the needs of the individual, not their condition.

Additionally, all health boards should ensure adequate access to patient information in a format that is accessible to them (e.g., [Move Better Gwent](#) and [Keeping Me Well](#)). This should include linking to third sector resources, interventions and digital applications that have demonstrated improvements in value and sustainability and that meet national requirements (procurement framework in construction by the Strategic Clinical Network for MSK Health CRG).

The Strategic Clinical Network for MSK Health will co-produce a tool kit to support rehabilitation delivery alongside the national person-centred rehabilitation lead.

3. Catchment Population and Population Need

3.1 Catchment Population

The population covered by this specification is patients usually registered with a General Practitioner in Wales or otherwise the responsibility of NHS Wales.

Whilst this specification relates to a life course approach, adaptations are needed to meet the unique needs of different age groups. Services should make adaptations to meet the unique needs of those below the age of 18 years, aligned to the [Transition and handover from children's to adult health services](#) and the [convention on the rights of the child](#). This should be through paediatric services and the development of appropriate adolescent services that may deliver care in appropriate settings whilst taking account of the needs of this age group. It is suggested that a person-centred and shared decision approach should be used with children and families when choosing which clinics they access. An annex will

be co-produced with the Child health network, Paediatric rheumatology and Paediatric orthopaedic reference groups to guide adaptations to meet the unique needs of children, adolescents and young adults.

3.2 Population Need

Recent scoping through the [NHS in 10 years](#) suggests that demand for MSK healthcare is expected to continue to grow predominantly due to improvements in healthcare, increasing public expectation and an ageing population.

With rising multimorbidity as a result of individuals living with multiple long term conditions healthcare needs of the population are changing. Services must adapt to meet this need and consider the importance of secondary prevention and supportive rehabilitation that reaches across these multiple morbidities. Condition agnostic, multi morbidity rehabilitation focused on living well with multiple long-term conditions will need to expand. Integrated MSK services are well placed to meet needs across the biopsychosocial spectrum and particularly in relation to activity and mobility.

Condition agnostic rehabilitation is one method by which we can meet these changing needs. Guidance will be developed in co-production with the national person-centred rehabilitation lead and included as an annex. Integrated MSK services should adopt this guidance and where appropriate utilise condition agnostic rehabilitation pathways to enable MSK speciality resources to meet the specialist population needs.

4. Quality and Patient Safety

4.1 Clinical Governance

Providers must have a robust clinical governance structure in place, including a regular programme of clinical audit, quality improvement and assurance.

Quality improvement and assurance mechanisms will be aligned to the delivery of this specification, published national pathways and attainment of the Quality statement for MSK Health.

Data collection systems should be aligned to the key performance indicators (KPI's) and audits included in this specification and must include the completion of patient reported outcome and experience measures (PROMS and PREMS).

Providers are required to participate in activities of the Wales Strategic Clinical Network for MSK Health, including peer review. A toolkit to support peer review will be co-produced and included as an annex.

Providers must adhere to the national and professional standards within this specification.

Each integrated MSK service provider must have a nominated lead for clinical governance, audit, and quality improvement.

Providers must be able to demonstrate effective implementation of evidence-based practice within MSK healthcare.

Providers must be able to demonstrate that they have a risk register in place together with an associated audit calendar which is regularly updated and acted upon.

Each health board provider should establish and maintain a planning and delivery group for MSK services. The group should be chaired by an executive lead or an individual with a clear line of accountability to a board level executive director, the group will include the following functions:

- Senior forum to consider and agree annual priorities for the service for inclusion in the IMTP.
- Monitoring of service issues/performance trends and ensuring optimal service delivery within the wider health board clinical model.
- Forum for the escalation of issues as appropriate within the health board structure and to the Strategic Clinical Network for MSK Health.
- Agreement of service development/action plans, e.g., in response to peer review recommendations.

4.2 NHS Wales Health and Care Standards

Quality is defined according to the [Duty of Quality Statutory Guidance 2023 and Health and care Quality standards 2023](#). The Quality statement for MSK Health and the framework for Arthritis and MSK conditions in Wales provide further guidance.



Figure 6: Diagram of the Health and Care Quality Standards

4.3 Data

Services will contribute to the development and agreement of condition, activity and outcome codes, which will be included as an annex. These will be aligned to subspeciality coding structures to provide seamless person level data. This will include:

- Outcomes from both patient-reported (MSK-HQ as a minimum and should be extended to include EQ5D5L and the friends and family test) and clinically reported measures.
- Staffing and consumable costs.
- Performance and productivity metrics.

4.4 Audit

Multiprofessional teams are expected to conduct regular audit and improvement reviews against expected standards, with reporting of these and significant events and complaints at least every other month. Audit should include local priorities in relation to this service specification, the quality statements for MSK Health, for specific MSK pathways and the community rehabilitation standards.

Where possible these audits should be held on the AMaT system to enable clear and transparent communication between services and the national networks.

5. Key Performance Indicators

The provider will be expected to monitor and report against the following performance and activity indicators. Indicators are subject to further development and change.

Key Performance Indicators

In order to quality improve services, we will be expected to report on the following measures:

Modernising Outpatient Data Set (MODS) referral data set (currently in construction)	
Request Source	The individual, or healthcare professional (which one)
Condition Codes	To be provided by referrer and amended after initial consultation if required
Activity Codes	To include investigations, interventions and supportive treatments
Exit Codes	Discharge, SOS and PIFU

Quality Indicators

Safe
Adherence to National pathways and guidance
Compliments, complaints and concerns - volume and nature
Timely
Triage for urgent requests within 1 day and routine requests within 3 days (% triaged within 1 or 3 days of receipt)
Urgent care not delivered in 2 weeks
Total wait (number of people awaiting a first appointment, broken down by number of weeks waiting)
Number of hits on self-management resource website
Effective
MSK-HQ – MCID achieved in post management in >75% of cases
Efficient
Total first contacts seen (number of people attending a first appointment)
Total FU seen (number of contacts after first appointment).
NP DNA (Percentage of new patients that DNA).
NP UTA (percentage of new patients that cancel an appointment)
Number of referrals within same conditions pathway
% discharged at first contact
% seen with same clinical condition within 6 months

% referred to subspecialist services AND % conversion to subspecialist intervention
Requests for further investigation (radiology, biochemistry and neurophysiology)
Cost per case
Equitable
Welsh Index of Multiple Deprivation (WIMD) data for those accessing services as compared to the local population
Person-centred
A PREM aligned to the rehabilitation framework.

6. Actions and Planning

Action	Priority	Responsible Individual	Timeline	Date for Completion
Clinical condition codes and Triage toolkit	Launch			
Optimisation framework Readiness /implementation toolkit	Launch			
Key performance indicators and data standards toolkit	Launch			
Subspeciality interface toolkit	Launch			
Workforce planning toolkit aligned to implications of this service specification	April 26			
Children and young people	April 26			
National scope for diagnostic investigations – linked to Pathways	April 26			
Implementation toolkit for the multiprofessional Primary and community care MSK capability framework	April 26			

Prevention based health and care toolkit	April 27			
Condition agnostic and multimorbidity rehabilitation toolkit	April 27			
Peer review toolkit	April 27			
Employment support toolkit	April 27			
Toolkit to support collaborative community working	April 27			

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