Supported Self-Management in Musculoskeletal Services

Toolkit for implementing supported self-management (SSM) in musculoskeletal (MSK) primary and community services

#BestMSKHealth Collaborative

Contents

Who is this toolkit for?

This toolkit is designed to be practical and user-friendly. It is primarily for MSK clinical teams who want to look at improving the support to patients to manage their MSK effectively, issues such as symptom management, treatment decisions and managing the impact of MSK conditions on their daily lives.

Its focus is supported self-management (SSM). However, for this to be effective patients and clinicians need to work in partnership based on a biopsychosocial model of health. We recognise issues such as digital access, commissioning and the interplay with other services play their part as well, so we have included information on these to.

You don't have to read it from cover- to-cover and you can dip in and out and focus on the areas where you will get the greatest benefits and improvement.

It is for anyone who wants to know more about supported self-management and improving care in MSK.
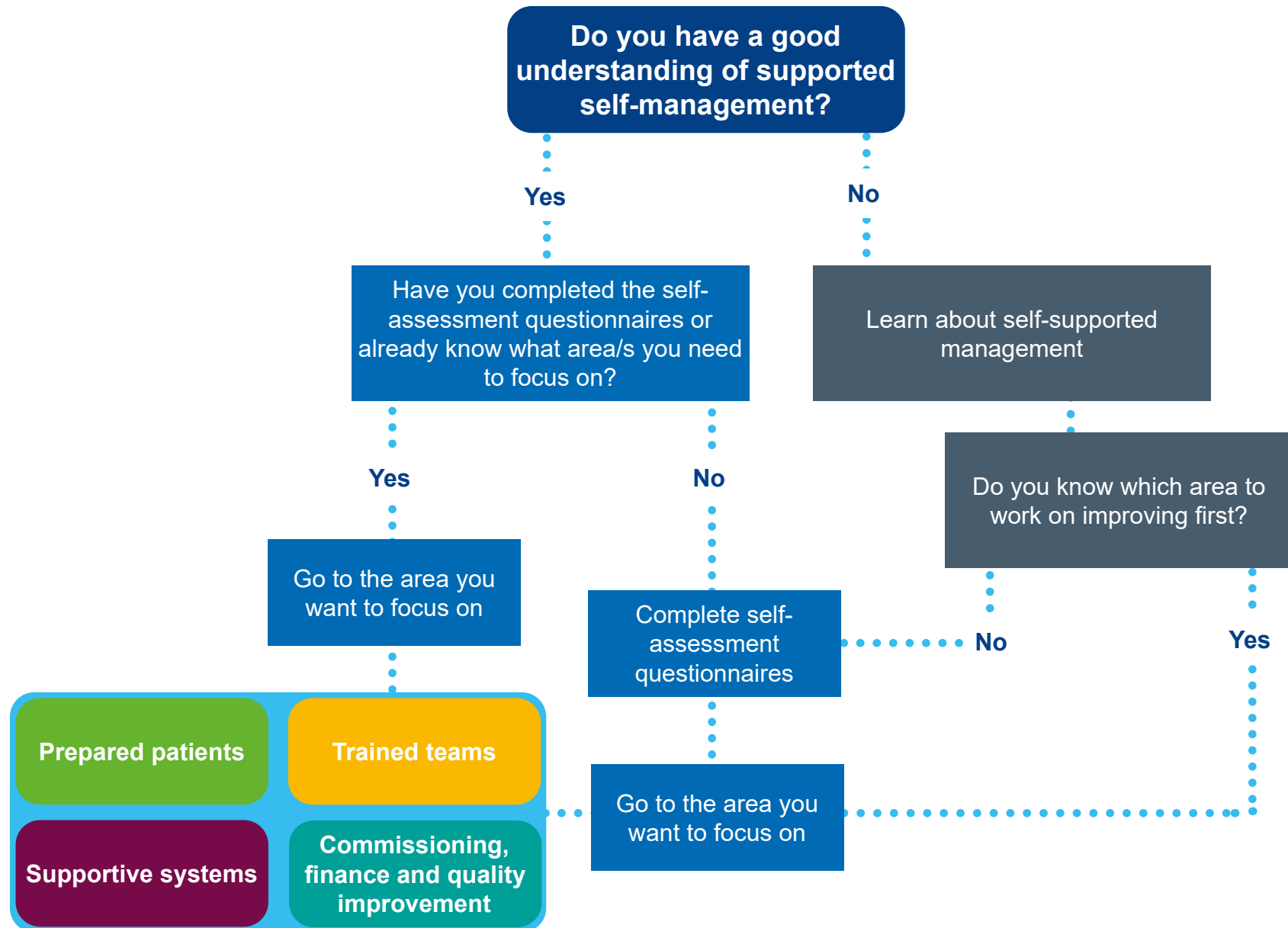
It has been developed by clinicians and experts in personalised care. Links to more detailed guides are provided as appropriate.

How to use this toolkit

Do you have a good understanding of supported self-management?

Yes

No

Have you completed the self-assessment questionnaires or already know what area/s you need to focus on?

Learn about self-supported management

Yes

No

Go to the area you want to focus on

Complete self-assessment questionnaires

Do you know which area to work on improving first?

No

Yes

Go to the area you want to focus on

Prepared patients

Trained teams

Supportive systems

Commissioning, finance and quality improvement

Introduction

People living with musculoskeletal (MSK) long term conditions, their families and carers make decisions and manage a broad range of factors that contribute to their health and wellbeing on a daily basis. Supported self-management acknowledges this and, where appropriate, supports people to develop the knowledge, skills and confidence they need to make optimal decisions and actions.

People who are confident, skilled and knowledgeable in managing their MSK:

- Will have less pain;
- Are more active;
- Are less likely to need surgery or need surgery later;
- Use fewer health resources;
- Have a lower risk of additional co-morbidities such as hypertension and diabetes;
- Are more likely to stay in or return to work.

It is important that people living with MSK long term conditions are active partners in determining outcomes that are important to them and how to achieve these working in collaboration with health and care professionals.
They should also be able to access support within and beyond health services to better manage their health and wellbeing on an ongoing basis.

1 Improving the care of people with long-term conditions in primary care: protocol for the ENHANCE pilot trial 2015

Why is change needed?

- Patients with MSK long-term conditions (LTCs) have poorer quality of life, poorer clinical outcomes, longer hospital stays and more post-operative complications, and are more costly to health services[1].
- We have an aging population with increasing numbers of people living with one or more long term conditions.
- The sheer scale of MSK long-term conditions challenge for modern healthcare systems means that we need a shift away from the 'medical model' of illness towards a model of care, which takes into account the expertise and resources of people with LTCs and their communities.
- Ensuring that people have access to a range of evidence-based options to manage their MSK condition that equally include biomedical and lifestyle approaches.

Spotlight on digital

As set out in the Long Term Plan and Topol Review, digitally-enabled care will become mainstream across the NHS with the aim to improve access, experience and outcome of care for the 20.3m people living with a musculoskeletal condition (Versus Arthritis, 2021).

You will see this logo in the toolkit every time there is a spotlight on a particular area of digital healthcare relating to musculoskeletal services.

digital literacy

[/ˈdɪdʒ.ɪ.təl/ /ˈlɪt.ər.ə.si/]

noun

Those capabilities that fit someone for living, learning, working, participating and thriving in a digital society.

Supported self-management

People have a key role in protecting their own health, choosing appropriate treatments and managing long-term conditions.

Issues such as loneliness, lifestyle and peoples ability to manage their health and wellbeing are key factors in how well people live with MSK. Self-management is a term used to include all the actions taken by people to manage their own health. They may do this independently or in partnership with the healthcare system.

Self-management education is any form of formal education or training for people with long-term conditions focused on helping them to develop the knowledge, skills and confidence they need to manage their own health care effectively. We use the term 'supported self-management' to mean the ways that health and care services encourage, support and empower people to manage their ongoing physical and mental health conditions themselves.

These are activities such as self-management education, health coaching and peer support.

Supported self-management is part of the NHS Long Term Plan's commitment to make personalised care the norm.

'What matters to me.'

The message in the Fuller Stock take (2022) was loud a clear: we must start with people's abilities and work with them to support self-care and self- management of complex and long-term conditions.

Key components of supported self-management

01
Self-management education

02
Health coaching: 1-1 and group

03
Peer support

04
Social prescribing

Click each item above to go to more information online

Supported self-management has been found to:

1 Improve mobility and symptom management

2 Reduce unplanned admissions, outpatient and primary care usage

3 Improve hypertension, HbA1c

4 Improve quality of life, self-confidence and outcomes that are important to individuals

5 Ensure services can be delivered in a more joined-up and cost-effective way

6 Enable professionals working in and beyond the NHS to have more meaningful conversations with people living with long-term conditions and greater impact from, and satisfaction with, their practice

1 Self-management capability in patients with long-term conditions is associated with reduced healthcare utilisation across a whole health economy: cross-sectional analysis of electronic health records. BMJ Quality & Safety 2018;27:989-999.

2 Deeny S, Thorlby R, Steventon A, 'Reducing emergency admissions'. Health Foundation; 2018

3 Maureen J. Lage & Kristina S. Boye (2020) The relationship between HbA1c reduction and healthcare costs among patients with type 2 diabetes: evidence from a U.S. claims database,
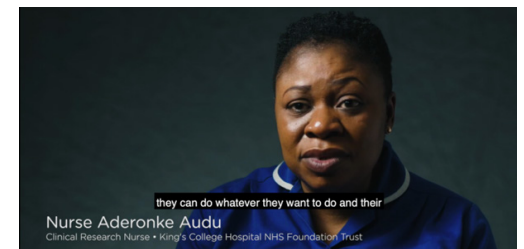
4 Supporting Self-Management. National Voices (2014)

5 Cost-effectiveness of Interventions to Manage Diabetes: Has the Evidence Changed Since 2008? Diabetes Care.

6 Improving communication between health care professionals and patients in the NHS in England

South East London Remote Monitoring Service

This film on Vimeo from Health Innovation Network explains how rheumatology services across South East London came together to design and implement a remote monitoring service to support patients monitor their rheumatoid arthritis at home.

they can do whatever they want to do and their

Nurse Aderonke Audu
Clinical Research Nurse • King's College Hospital NHS Foundation Trust

Digital health: from sharing to empowering

Virtually every aspect of modern life has been, and will continue to be, radically reshaped by innovation and technology – and healthcare is no exception.

Greater use of technology and data along the MSK care pathway provides many opportunities to support people to receive care and advice closer to or at home when needed the most through remote monitoring apps, wearable devices and online self-management resources.

Connecting patient health records and expanding the use of the NHS app offer greater access to appointment booking and test results and for staff more joined up information to support shared decision-making about care.

Melanie Martin, Senior Delivery Manager in the Digital Care Models team in NHS England, has applied her 25 years of experience as an MSK physiotherapist working across primary, community and secondary care to lead the co-production of a digital strategy to complement the ambitions of the Best MSK Health programme.

Melanie said: "The National Best MSK Health programme is an opportunity to digitise, connect and sustainably transform the MSK health of the nation.

"Working together with lived experience partners, integrated care system leaders and the national team, we can support people to feel in control of their health and data from which new evidenced-based models of care can emerge through leveraging the potential of technology.

"A digital strategy will set the direction for inclusive digital transformation of MSK care, co-owned by those with lived experience and will be a key enabler for the Best MSK high impact strategy."

'Connecting people across all communities with inclusive, personalised and digitally-enabled care to support best musculoskeletal health for all' with the aim of 'Putting people at the heart of what really matters to transform care with data and technology to enable best musculoskeletal health for all'.

Best MSK Health Digital Strategy vision statement, co-produced with the MSK community of practice

Find out more by joining the free online [Best MSK Digital Health Exchange Community of Practice](#).

Toolkit on a page: Supported Self-Management in Musculoskeletal Services

System improvement priorities and actions

1. Prepared patients

1. Agenda sheets sent to patients before consultation
2. Fully involved in shared decision making: if diagnosis is known and DST is available, send to patient before consultation
3. Access to a menu of self-management options
4. Patient held record (PHR) – person holds/has access to digitally
5. Personalised care and support plan in place
6. Accessible and clear information available
7. Access to peer support

2. Trained teams

1. Clinicians access and complete recommended training as set out in CPD and roadmaps.
2. Confident in exploring with patients the most relevant self-management support option.
3. Training in behaviour change
4. Named clinical champion for SSM and SDM
5. Audit SDM and SSM activity
6. Trained in SDM and to use decision support tools (DSTs)
7. Effective team working and communication
8. Routine Use of PROMS and PREMS for quality improvement

3. Supportive systems

1. Digital Personalised Care and Support Plans linked to clinical record
2. Digital PROMS/PREMS, including individualised PROMs
3. Directory of services supporting signposting to VCSE and community assets
4. Enable direct and self-referral to peer support and self-management support
5. Data sharing – across health and care providers
6. System leadership

4. Commissioning, finance and quality improvement

1. Funding streams fully utilised
2. Utilising shared resources
3. Caseloads, flow rate and capacity modelled and recruited to
4. Costs, return on investment, new cost and repurposing existing funding and contract variations
5. Quality improvement methodology in place to inform commissioning and contracting

5. Digital

Self-assessment questionnaires

'What matters to me'

The first two sections of this toolkit - Prepared patients and Trained teams - discuss interventions and approaches that can be implemented by clinical teams, drawing on support from other roles such as health and wellbeing coaches.

This does not require additional funding, but it does requre a willingness to implement and work through barriers and problems that may arise.

It is suggested to only implement one action at a time.

WHAT MATTERS TO ME

1. Working in partnership with my clinician & wider care team
Shared decision making

2. Choosing from the available options
Enabling choice

3. Building my knowledge, skills & confidence
Health coaching & supported self-management

4. Connecting to help & support in my community
Social prescribing

5. Designing my own plan, supported by professionals
Personalised care & support planning

6. Managing my own budget & support, with help if I choose
Personal health budgets & integrated personal budgets

Self-assessment questionnaire - ready reckoners

Tick each of the items you are already doing, then chose just one item to implement or improve at a time

1. Prepared patients

If asked, how would your patients answer?

	I feel prepared for appointments.
	I am able to understand information given to me about my health condition.
	I am sent information about different treatment options in a format that I find easy to understand before/after an appointment.
	I feel fully involved in decisions about my treatment and care, including things I can do for myself.
	I know where there is a peer support group if I want to use it.
	I am aware of and access the different types of support available to help me manage my health condition on a day-to-day basis.
	When first diagnosed or when I was struggling I was offered self-management education or health coaching if appropriate.
	I am confident that I can access my own records and understand them.

2. Trained teams

Can your team answer the following?

All our team have accessed and completed recommended training as set out in CPD and roadmaps.

I have accessed and completed the 30-min SDM e-learning via Personalised Care Institute as minimum and/or completed other SDM training.

I have completed the PCI personalised care and support planning eLearning.

I am aware of the personalised care competencies and training in the practitioner roadmaps.

I can demonstrate skills and understanding in behaviour change (for example health coaching, motivational interviewing, COM-B and MECC approaches).

I am confident I can identify patients with low health literacy/activation.

I regularly discuss with patients options for self-management support including mental health and employment.

There is a named clinical champion for SSM and SDM and I know who they are.

I have trained in use of decision support tools (DSTs) and am confident in using them.

In our MDT we regularly discuss issues such as health literacy and social determinates in helping to identify patients with additional support needs early on.

3. Supportive systems

Can your team answer the following?

	We have Digital Personalised Care and Support Plans linked to clinical records
	We have digital PROMS/PREMS, including individualised PROMs, which let people identify issues that matter most to them
	We have a directory of services supporting signposting to voluntary, community and social enterprises
	We have enabled direct and self-referral to peer support and self-management support
	We share data across health and care providers
	We have a senior leader who is accountable and responsible for the embedding of shared decision-making across our organisation

4. Commissioning, finance and quality improvement

Can your team answer the following?

	Our funding streams are fully utilised
	We utilise our shared resources
	Our caseloads, flow rate and capacity are modelled and recruited to
	We review our costs, return on investment, new costs and funding and contract variations
	We have quality improvement methodology in place to inform commissioning and contracting

Prepared patients

Ensuring patients feel informed and empowered, not only during but before and after their appointments, is vital in helping them to take more control of their health. This represents a new relationship between people, professionals and the health and care system, with a positive shift in power and decision-making that enables people to feel informed, have a voice, and be heard.

This shift is important as there is a direct correlation between a person's confidence, knowledge and skills in managing their health and wellbeing, and disease progression, service utillisation and quality of life. But while most people want to take more control of their health, they may not expect to play a leading role, and active steps need to be taken to prepare them for this new way of working.

Actions

1. Agenda sheets sent to patients before consultation

Information and resources

- Sent to patients, agenda setting sheets provide prompts for the patient to consider what's important to them and what they may want from a consultation. Patients and clinicians should jointly agree the aims of each meeting they have. Evidence shows that when this does not happen effectively, patients feel dissatisfied with their experience. In addition, they are less likely to become 'active patients' and adhere to treatment advice, act on lifestyle change advice or even attend their next appointment.

- Establishing the patient's perspective at the start helps clinicians to work with the patients.

- Own motivations and interests and improve both patient experience and outcome.

- Clinicians should develop a template for a shared agenda and send this to patients prior to the appointment, in order to enable the patient to prepare for the appointment and make best use of the consultation time.

Top tip

When this is first done many patients won't fill them in prior to consultation. It is important that the agenda sheet is still used in the consultation and the questions asked so that patients begin to expect to reflect on what is important to them, and what they want out of the consultation. **Remember - changing expectations and behaviours takes time.**

Actions

2. Shared decision making: If diagnosis is known and decision support tool (DST) is available, send to patient before consultation

Information and resources

- Shared decision making is a collaborative process that involves a person and their healthcare professional working together to reach a joint decision about treatment and care. It could be caring for the person's needs straight away or options in the future.

- It's important that the patient has the capability and skills to participate in SDM. A lot of decisions are made early on when a person's knowledge and skills in managing their condition may be much lower than someone who has been living with a condition for some time. It's important to be able to assess a person's level of health literacy and tailor the consultation and information accordingly.

- There are tools that help assess their knowledge, skills and confidence, including these tools on the NHS England website.

- It is better is not to assume but to use health literacy skills, which can be found by accessing the PCI health literacy training.

Encourage the patient to ask questions

- Ask 3 Questions has resources to help increase individuals' awareness of shared decision making, increase their expectations for a shared decision making consultation, and provide them with a way of taking part in shared decision making.

- It's okay to ask is a leaflet designed to encourage patients to ask the questions that matter to them.

- BRAN is a Choosing Wisely UK and Association of Medical Royal Colleges campaign to encourage individuals to ask their doctor or nurse four questions to make better decisions together.

- Getting ready to talk about your health is a public-facing infographic to prepare patients for their appointments (this document is on FutureNHS, which is free to join).

- Preparing patients for their appointments system guidance (this document is on FutureNHS, which requires signing in. It is free to join).

Access to resources

- If appropriate, ensure patients have access to up-to-date and accessible decision support resources, such as those on the Versus Arthritis website and NHS England's decision support tools.

| **Actions** | **Information and resources** |

3. Access to self-management options

These fall into these main categories: self-management education, information (see Action 6), health coaching, peer support (see Action 7), and community-based support via social prescribing.

Self-management education

This may be face to face or online, group based or individual depending on peoples needs. Typically courses run for 6 weeks for 2 hours each week and cover a rage of topics aimed at increasing people's skills, knowledge and confidence in managing their health. A range of materials and an example of a online course can be found here [Patient Resources | CEmPaC](#) all of these resources are license free and are available to adapt.

Health coaching

Health and wellbeing coaches are employed in most primary care networks and support people to increase their ability to self-manage, motivation levels and commitment to change their lifestyle. They are experts in behaviour change and focus on improving health related outcomes by working with people to set personalised goals and change their behaviours. They work with people with physical and/or mental health conditions and those at risk of developing them. Health coaches can be utilised to run self-management courses and support peer support groups.

Health coaching can be an effective intervention for people experiencing a range of long-term conditions as well as MSK, including respiratory, cardiovascular (including type 2 diabetes and hypertension), and stress/low mood. They can also support people with weight management, diet and increasing activity levels.

Community-based support via social prescribing

Social prescribing is a way for local agencies to refer people to a link worker. Link workers give people time, focusing on 'what matters to me' and taking a holistic approach to people's health and wellbeing. They connect people to community groups and statutory services for practical and emotional support such as employment support. Link workers also support existing community groups to be accessible and sustainable, and help people to start new groups, working collaboratively with all local partners.

- [A practical guide to self-management support - The Health Foundation](#)
- [NHS England » Health and wellbeing coaches](#)
- [SSM Summary Guide.docx (england.nhs.uk)](#)
- [NHS England » Social prescribing](#)
- [Making it happen: Practical learning and tips from the five Realising the Value local partner sites | Nesta](#)

Actions	Information and resources
4. Patient held record (PHR) - person holds/has access to digitally	• By creating a patient held record (PHR), service users and patients will be in charge of their own care, working in partnership with those who care for them. They will record information about their own health and wellbeing, have access to health apps, medical expertise and be able to view the relevant parts of their health records. They will be able to share their records with other health professionals, carers and family members if they wish. • For clinicians, they will be able to see all the relevant care records for a person in one place and be able to see what that person has recorded about their own health, such as their mood.
5. Personalised care and support plan in place	• Personalised care and support planning is a series of facilitated conversations in which the person, or those who know them well, actively participates to explore the management of their health and well-being within the context of their whole life and family situation. • Personalised care and support planning is key for people receiving health and social care services. It is an essential tool to integrate the person's experience of all the services they access so they have one joined-up plan that covers their health and wellbeing needs. • The process recognises the person's skills and strengths, as well as their experiences and the things that matter the most to them. It addresses the things that are not working in the person's life and identifies outcomes or goals and actions to resolve these. • NHS England » Personalised care and support planning
6. Accessible and clear information	• Health Literacy Toolkit - Ensuring individuals and communities can access, understand, appraise and use information and services to make decisions about health is key to health literacy. Improving people's health literacy will enhance their ability to self-manage their health. • Health Literacy E-learning - The e-learning session takes about 30 minutes to complete. At the end of the session, you will know why health literacy is important and how to use some simple techniques including TeachBack, chunk and check, using pictures and simple language to improve how you communicate and check understanding with others. • It's okay to ask is a leaflet designed to encourage patients to ask the questions that matter to them. • All Information should follow the Accessible Information Standard. • About The Patient Information Forum	Patient Information Forum (pifonline.org.uk)

Actions	Information and resources
7. Access to peer support	• Peer support is a range of approaches through which people with similar long-term conditions or health experiences support each other to better understand the conditions and aid recovery or self-management. • Peer support may be formal or informal; it can be delivered by trained peer support staff and volunteers, or through more informal, ad-hoc support among peers with lived experience. • The Community capacity and peer support guide includes a common framework for developing formal and informal peer support options and how to put them into practice. • National Voices has launched a Peer Support Hub an online bank of high quality resources for people looking to measure, evaluate, sustain and grow different types of peer support. • More information about the successful implementation of peer support, can be found in the Realising the Value Programme, which was commissioned by NHS England. • There are a number of national charities and organisations that provide advice and information (including telephone helplines, videos and webinars), access to peer support (including online forums), and exercise groups to help people manage their condition/s. For musculoskeletal conditions these include: • Arthritis Action – self-management and wellbeing resources, weight management and exercise support, local peer-support groups. • Ehlers Danlos Support UK – helpline, support groups and online information resources • Fibromyalgia Action UK – helpline and support groups • Hypermobility Syndrome Association – helpline and support groups • National Axial Spondyloarthritis Society has local support groups and a national helpline. • National Rheumatoid Arthritis Society has a helpline, local and virtual NRAS groups, free resources and a supported self-management programme. • Polymyalgia Rheumatica & Giant Cell Arteritis UK – local groups, helpline • Psoriasis Association (including psoriatic arthritis) – helpline and online forums. • Royal Osteoporosis Society - support groups and a helpline • Scleroderma and Raynaud's UK – helpline, support groups and online information resources.

Actions	Information and resources

Actions

7. Access to peer support (continued)

Information and resources

- UK Gout Society – online information

- Versus Arthritis – helpline, online chat bot (available to answer common questions 24/7) and local groups and services.

- CCAA (Kids with Arthritis) supports children, young people and their families.

- JIA@NRAS provides a comprehensive website, free resources and peer support.

- Personalised Care: Peer Leadership is a free online course created by the Personalised Care Group at NHS England. This course is open to everyone but is mainly aimed at people with long-term conditions and disabilities and their carers who want to improve their situation by gaining knowledge of personalised care.

Personalised care roles

- Care coordinators are employed by some primary care networks to work with people to develop their personalised care and support plans and to prepare for SDM conversations. They can connect people with other NHS and care services and support and could also help people to follow up appointments in secondary care or find out what has happened to a referral.

- Health and Wellbeing Coaches who are employed by some PCNs. Health and Wellbeing Coaches help people to make changes to health-related behaviours and to become more active in looking after their health. They can, for example, work with people who are keen to get fit before surgery and would like motivation and support with this and people who are living with chronic pain.

- Social Prescribing Link Workers (SPLWs) work in primary care networks (PCNs) as part of the multi-disciplinary team. SPLWs take referrals from a range of agencies, including GPs and other health services. This means that individuals can be referred to SPLWs from Post COVID-19 assessment centres.
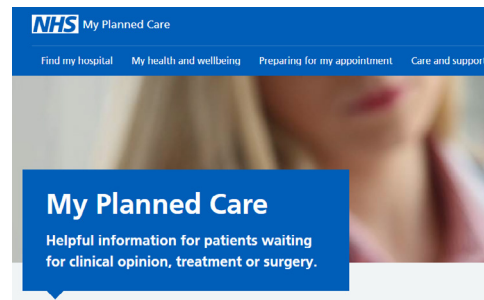
Case study

["Move with Leon"](#)
programme for patients with MSK conditions who want more movement in their lives

Online tools to support shared decision making

[My Planned Care](#) gives people advice and support while they wait and helps them prepare for their hospital consultation, treatment, or surgery. This includes giving them information about waiting times at their hospital and other supporting and local services while they wait.

[Torbay Charts](#) is a new style of online patient decision aid, designed to help patients and health professionals make decisions together about a course of care.
It approaches shared decision making and patient decision aids in a new and engaging way by providing information in stages and adaptable formats.
Torbay Charts allow patients to compare different treatment options side-by-side through tick boxes on the overview page.
This means they can drive the comparison themselves and make a truly informed decision about which treatment is right for them.

Trained teams

'Trained teams' refers to the competencies, behaviours, opportunities and motivation to support people to develop the knowledge, skills and confidence to be active partners in managing their health condition/s.

It is vital that teams recognise that a significant part of health outcomes are under the control of the patient. Teams need to take a quality improvement approach to implementing new approaches or reviewing existing practice. Many of the activities covered in this section are skill based, acquired through interactive training.

Actions	Information and resources
1. Clinicians have accessed and completed recommended training as set out in CPD and roadmaps	• Personalised Care Institute provides training resources to equip health and care professionals with the knowledge, skills and confidence to help patients get more involved in decisions about their care. These sections, in particular, are recommended: • Core Skills for Personalised Care • Shared Decision Making • Personalised Care and Support Planning • Roadmaps to Practice: A supportive document that provides a clear educational pathway from undergraduate to advanced practice for clinicians in primary care

Health Education England's A Health and Care Digital Capabilities Framework is a developmental and supportive tool to empower and enable all staff. It offers guidance towards extending health and care professionals' digital capabilities to be able to provide better care in our complex, ever-changing digital world.

Actions	Information and resources

2. Training in behaviour changes	• A significant percentage of people find it difficult to move from understanding the need to change health related behaviors to implementing the change. Training in behaviour change means clinicians are more able to support patients to make changes including following through treatments or losing weight prior to surgery.
	
	• Find out more about individual-level interventions aimed at supporting people to change health behaviours:
	  • Making Every Contact Count (MECC)
	  • Health Coaching
	  • Motivational interviewing
	  • Introduction to COM-B model of behaviour

3. There is a named clinical champion for Self-Supported Management (SSM) and Shared Decision Making (SDM)	• A team's clinical champion is responsible for advocating for change, motivating others, and facilitating the adoption of innovation and evidence-based practices.
	  • Supported Self-Management (SSM)
	  • Shared Decision-Making

4. Audit Shared Decision Making (SDM) and Supported Self-Management activity (SSM)	Plans should be made how to audit and evaluate the SDM and SSM activity in order to evidence that this is taking place: • Steps for planning how to use measurement within supported self-management, based on evidence and good practice.

5. Trained in use of decision support tools (DSTs)	• It is important to ensure that key staff members are trained in the use of decision support tools. DSTs are a set of questions and answers to help people living with a health condition make informed choices about their treatments. They are used together with a healthcare professional to support a conversation, taking into account the context of people's lives, and not assuming that there is a single 'best' option for everyone.
	  • NHS England decision support tools
	  • Versus Arthritis has produced a suite of support tools to help people with back, shoulder, hip and knee pain.

Actions	Information and resources
6. Effective team working and communication	• Multi-disciplinary teams (MDTs) are the mechanism for organising and coordinating health and care services to meet the needs of individuals with complex care needs. The teams bring together the expertise and skills of different professionals to assess, plan and manage care jointly. Based in the community, and networked with primary care, MDTs are expected to work proactively to support individuals' care goals. • Including health and wellbeing coaches in the MDT enables colleagues to support people with their behavioural, social, emotional and practical needs as well clinical treatments. The unique contribution of a health and wellbeing coach is that they understand the person and their motivations to develop new ways of working with them to develop their capability to make and sustain healthy lifestyle choices. These changes could result in positive clinical outcomes. • Health Education England Multi-disciplinary Team Toolkit.

7. Routine Use of Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) for QI	• It is important to be able to demonstrate that supported self-management has an effect on outcomes and/or experience:
	  • PROMS (Patient-Reported Outcome Measures)
	• PREMS can take the form of:
	  • Functional questionnaires that ask the patient about practical issues such as waiting times and facilities.
	  • Relational questionnaires that ask the patient about their experience of the treatment relationship. For example did they feel listened to, could they take part in the decision-making.

The next two sections outline some of the wider system and finance enablers that may need to be considered at neighbourhood and integrated care system levels

Supportive systems

Supportive systems are the structural and procedural activities that support the other areas of supported self-management. Activities include administration, quality of information, access, clinic set up and times.

This also involves the role of clinical and senior leadership. These are areas that are often out of the control of the patient and clinical team.

Actions	Information and resources
1. Digital Personalised Care and Support Plans linked to clinical record	• Personalised care planning standards will help to enable people to manage their own care, with the support of a wide range of services including GPs, hospitals, occupational therapy and social care. • This new digital standard will help patients and health and care professionals get the right information when they need it, in order to personalise care, and improve the experience for the patient, their carer and their families. • Information on the standard can be found here: https://theprsb.org/standards/personalisedcareandsupportplan/
2. Digital PROMS/ PREMS – including individualised PROMs which let people identify issues that matter most to them	• Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) are important to ensure that you know what is making a difference. • A standard set of MSK PROMS can be accessed on the Versus Arthritis website. • PREMS can take the form of functional questionnaires that ask the patient about practical issues such as waiting times and facilities. • Relational questionnaires that ask the patient about their experience of the treatment relationship. For example did they feel listened to, could they take part in the decision-making.

Actions	Information and resources

3. Directory of services – supporting signposting to voluntary, community and social enterprises

- Your local social prescribers/social prescribing team are likely to have already mapped community assets – set up for social prescribing services vary across primary care networks.

- It is important that teams are aware of local services and community assets.

- Local teams should draw up their own MSK-focused list and ensure everyone on the team is aware of it. As part of this exercise, teams should identify any gaps and address these.

4. Enable direct and self referral to peer support and self- management support

- Self-referral allows patients to refer to some MSK and physiotherapy services without seeing their GP first. A single point of referral, combined with online self-referral for MSK conditions, is effective for shortening the waiting times for physiotherapy, occupational therapy and orthopaedic triage patients.

- There are a number of national charities and organisations that provide advice and information (including telephone helplines, videos and webinars) access to peer support (including online forums) and exercise groups from walking to swimming and hydrotherapy that will help manage MSK symptoms including. See Page 17 for more details.

- In addition, a number of self-management options can be found in the Prepared Patients part of the toolkit.

- Case study: How does self-referral support person-centred care?

Actions

5. Data sharing - across health and care providers

Information and resources

Sharing data with patients

- In line with the NHS Long Term Plan and Data Saves Lives, the NHS is working to make it easier for patients to digitally access their future health information in their general practice records. In April 2020 NHS England introduced an obligation for practices to give patients access to their prospective (future) medical record online (including free text and documents).

- Better access to health information enables patients to become partners in managing their health. Evidence has shown that this increases patients' feelings of autonomy and reduces the need for patients to contact general practice.

- From 1 November 2022, patients at practices using TPP and EMIS systems will automatically have access to their prospective records online. Work is ongoing with Cegedim (previously Vision) to create the same functionality. This does not change the status of general practices as a data controller or alter existing obligations to promote and offer access to historic information.

- There are a number of resources available to support preparing for the change, including a series of webinars for practices and commissioners. These are available at https://digital.nhs.uk/records

- There are a range of other options – one that is on NHS England's HSSF Framework is Patient Knows Best

Sharing data with partners

- If a patient's care crosses multiple organisations and includes remote options it is important to ensure that information is appropriately shared (in line with GDPR regulations).

[Virtual multi-disciplinary team meeting to support staff to deliver care and advice remotely](#)

[Virtual fracture clinic for patients with acute bone injury not requiring immediate on-call review](#)

Actions	Information and resources

Actions

6. System leadership

Information and resources

- System leadership is about working beyond organisational boundaries on challenges of mutual concern that cannot be solved by any one person or institution. The system is no longer focused on operating as sole organisations and calls for a collaborative approach across a variety of new boundaries. It's also how to embody future focused inclusive leadership qualities.

- The new Integrated Care Systems (ICSs) - partnerships of organisations that come together to plan and deliver joined up health and care services – can provide a basis for this work.

- The Working in partnership with people and communities statutory guidance supports Integrated Care Boards, NHS Trusts and Foundation Trusts to build collaborative and meaningful partnerships that start with people, address health inequalities, and focus on what really matters to our communities.

- NICE recommends making a senior leader accountable and responsible for the leadership and embedding of shared decision-making across every organisation or system regardless of its size. This should be a board member or, if the organisation does not have a board, a leader at the highest level of the organisation.

- Find out more through our podcasts, short films and case studies about how integrated care across the NHS is changing and developing to better meet people's needs. LINKS need adding back in

Video consultations in North Tyneside Integrated Musculoskeletal service

The use of video supported the service to all but clear their backlog of patients who had either had an appointment cancelled or who were waiting to be seen. The service expected to have an almost clear slate once they were beyond the COVID-19 challenge.

Actions

6. System leadership resources

Information and resources

- Changing lives, changing places, changing systems- report from National Voices exploring planning, funding and delivering social prescribing services and the community activities, groups and services upon which they rely across places and within new Integrated Care Systems.

- A personalised outpatient model can offer patients care that is better tailored to individual need and circumstance, delivered through traditional means when required but also empowering self-management, remote-monitoring and other alternatives where clinically appropriate. It should improve quality of care and patient outcomes.

Partnerships and Leadership

- Podcast: Working with the voluntary sector. Explores the value of a joined-up way of working between systems and the voluntary sector, identifying the benefits of voluntary sector involvement in health and care partnerships and what this means for clinicians and their patients.

- Podcast: How clinical leadership makes a system. Clinical leaders come together to discuss the importance of clinical representation in leadership roles and the benefits they can bring to ICSs.

Case study: Personalised care and chronic MSK pain initiative

A new model of care for patients with chronic pain in primary care, developed from a pilot project, which aimed to:

- Improve health and wellbeing of patients with long term chronic pain;

- Offer patients an individualised and self supported personalised approach to managing their pain;

- Work predominantly in primary and community settings with support from an multi disciplinary team to address patients' wider needs;

- Address health inequalities through implementation of NHS England personalised care model.

Commissioning, finance and quality improvement

These are often activities that need to be managed at ICS (integrated care system) level and may combine resources for several clinical pathways and PCNs (primary care networks). Examples include resource mapping, use of roles such as health coaches and social prescribing.

They may include activities that look at best use of existing data sets for quality improvement and benchmarking and comparison against other areas and current use of PROMS and PREMS for understanding impact.

Actions	Information and resources
1. Funding streams fully utilised	• Check Allocations to the system from NHS England • The Additional Roles Reimbursement Scheme can be utilised to fund non-clinical roles within multi disciplinary teams • The Long Term Conditions Financial modelling tool can help organisations to understand the financial and/or activity implications for models of care for people with LTC, across different cohorts of patients and settings - this can help with business cases. • NESTA has also produced an impact and cost economic modelling tool.
2. Utilising shared resources	Resources can be shared across PCNs – in particular Additional Roles Reimbursement Scheme (ARRS) roles such as health and wellbeing coaches, care coordinators and social prescribers. NHS England has a ready reckoner for funding of the ARRS roles.

Actions	Information and resources
3. Case loads, flow rate and capacity modelled and recruited to	Reducing current waiting times requires a reduction in backlog of patients at every stage of the journey. Looking at and matching capacity and demand is a key approach to removing some of the visible and hidden backlogs along the patient pathway. Below is guidance on demand and capacity mapping, NHS England resources as well as a direct link to introductory training. • Demand and Capacity - A Comprehensive Guide - NHS Institute for Innovation and Improvement (nationalarchives.gov.uk) • NHS England » Fundamental concepts in demand and capacity • NHS England » Our introductory training • OHID's Musculoskeletal Conditions profile provides local data on prevalence rates and risk factors to enable commissioners to understand the unique health needs of local populations.

4. Costs, return on investment, new cost and repurposing existing funding and contract variations	• The musculoskeletal conditions Return on Investment Tool can help local commissioners provide cost-effective interventions for the prevention and treatment of musculoskeletal conditions
	
	• The Finance, Commissioning and Contracting Handbook – enables staff to understand what the expansion of personalised care programme means for their areas of work locally with practical tools and recommendations to enable sustainable change. – includes identifying cohorts , developing service specifications, agreeing meaningful data and metrics, funding models for contracting personalised care, the recommended commissioning cycle process, information and data sharing considerations, working with partners for achieving integrated commission.
	
	• As part of Realising the Value, an economic modelling tool for commissioners has been developed - NWL Primary Care Modelling. The tool consists of an economic model in the form of an Excel spreadsheet, and a user guide which explains how to use the model. The is designed to:
	
	    • Help commissioners (the intended users of the tool) evaluate the potential impact of investing in person and community-centred approaches for health and wellbeing in their local area;
	
	    • Give people the opportunity to access and benefit from these approaches in their local area.

Actions

5. Quality improvement methodology in place to inform commissioning and contracting

Information and resources

- NHS England » Transforming musculoskeletal and orthopaedic elective care services
- This musculoskeletal and orthopaedic elective care services handbook aims to support local health and care systems to work together to:
  - Better manage rising demand for elective care services;
  - Improve patient experience and access to care;
  - Provide more integrated, person-centred care.
- Standard MSK metrics are here: https://future.nhs.uk/NationalMSKHealth/view?objectId=34990064
- Quality from a patients perspective: A guide for commisisoners