NHS
Mersey Care
NHS Foundation Trust

NHS
Southport and
Ormskirk Hospital
NHS Trust

Musculoskeletal Service

Why co-production matters

Enter

Introduction

Across the Cheshire and Merseyside Musculoskeletal (MSK) Network, we recognised that our existing MSK services were not truly co-produced with patients. We wanted to have clarity about what mattered to people using MSK services and to find out what the people we serve want and need to support them on their MSK journey.

To explore this, two Trusts within the network, Mersey Care NHS Foundation Trust and Southport and Ormskirk Hospitals NHS Trust, undertook a collaborative pilot project particularly focusing on the early part of the patient pathway within MSK services.

We were aware from previous research and interactions with patients, that people often report feeling like they are manipulated to fit the system. They feel they do not fit in 'a box' and this can hugely impact personal recovery/condition management.

We anticipated that by nurturing a culture of co-production, involving the relevant people in conversations, and amplifying the voices of people with lived experience, future service development would be sustainable and of value to all.

Our co-production timeline

Planning session

Initial meeting between clinicians and representatives from the Personalised Care Institute (PCI) to provide context and background to co-production and to formulate an approach to delivery of the first group session.

Key topics:

1. Developed a mutual understanding of the key elements of co-production guided by the PCI
2. Discussed how we could support people to be involved and what would make it easier for them
3. Developed a communication strategy to attract people with MSK conditions to join the co-production group including the development of leaflets/posters; social media campaign; liaison with local networks and charitable organisations
4. Developed a framework of how the sessions would be delivered including a commitment to undertake a debrief within two weeks of the co-production session to ensure key messages had been heard and understood. We planned to record sessions, if agreed by the group, to allow the facilitators to revisit and reflect on each session prior to the debrief

Our co-production timeline

Communication strategy

Following the planning session, we implemented the communication strategy to find people who would be willing to participate in the group.

Once we had sufficient numbers, we organised a group session on Microsoft Teams and supported people unfamiliar with Teams prior to the first session.

Session one and two (with co-production group)

The introductory sessions began with a presentation of the key elements of successful co-production as we were aware many in the group had limited knowledge of this type of approach. We focussed on the importance of people's personal perspectives and their own lived experience in guiding how we deliver services in the future.

Key topics:

1. Introduction of co-production methodology
2. Set context with reference to current MSK services available in the region
3. Allowed time for each participant to share their own story in relation to their experience of MSK services
4. Reflected on what had been heard to ensure this was representative of what people had shared.

Our co-production timeline

Session three and four

Following session two, once the group was established and we had listened to everyone's experience and agreed the key themes, we then used an immersive situation technique, 'In Meg's Shoes' to explore how we could improve people's experience of MSK services.

Meg was a fictitious patient who was trying to get assistance and support from the initial onset of an episode of MSK pain. The group discussed what would be the ideal pathway for Meg from the very start of her journey to referral to specialist services should her symptoms not resolve.

Throughout the sessions we gathered key themes that the facilitators reported back to the participants to make sure we had a true representation of the group's views. From the early sessions, the facilitating clinicians immediately started to feedback to our wider networks what we were learning and kept the group informed of this, so they realised their feedback was already having an impact. We felt this was important to keep the group engaged and motivated.

Session five

In the final session we reflected on our co-production journey, what we had learned and any actions already in place.

We then discussed and agreed on both the short term and long term next steps for the group. In the short term we agreed to focus on amplifying the voice of the patient via our own networks and in particular, across the Cheshire and Merseyside NHS network to ensure the group's feedback was influencing service development.

Secondly, we agreed that we would use the feedback to develop a pilot project to establish a new pathway for patients with Fibromyalgia. This had emerged as an area where services were not meeting people's needs.

In the longer term we discussed reconvening the group to look at the MSK pathway once patients had a confirmed diagnosis and were still under the care of MSK services.

How has the service benefited to date?

Regional and National feedback

The two main clinical facilitators take part in the Cheshire and Merseyside MSK network meeting alongside other regional and national meetings; we have fed back our findings from the co-production work on a regular basis and have summarised learning using key theme analysis and word clouds.

Our aim is that others will replicate our work and co-production for service redesign in musculoskeletal services will become business as usual.

Key theme analysis

Access to clear and accurate information

What people want to see	What people DO NOT want to see
• Access to clear and consistent information – particularly for those with complex/ chronic conditions.	• Confusing information – leading to navigation of a complex system.

Access to treatment and care when it is required and not a set monthly follow up

What people want to see	What people DO NOT want to see
• Virtual/ telephone consultations as an option - not replace face to face completely. • Access to treatment when it is required, not a blanket set review. • Options of where to access support, guidance, and information.	• Poor access to advice. • Conflicting advice. • Lack of communication from services leaving people feeling anxious, abandoned and with no one to talk to about their concerns.

Mental health and wellbeing

What people want to see	What people DO NOT want to see
• Request for networking and peer patient support/ social contact. • Integrated physical mental health-well-being care; more publicity about talking-support services. • Normal exercise groups and facilities, e.g., pool-based exercise classes.	• Silo working of services. • Lack of clinician understanding and impacts well being can have on physical health.

Key theme analysis

Peer support and self-management

What people want to see	What people DO NOT want to see
• Person-centred holistic care is provided. • Rehabilitation' services supporting a range of comorbidities. • Self-help support groups could network to spread support more widely.	• A leaflet with no additional input.

Pain and symptoms support

What people want to see	What people DO NOT want to see
• Need for services to be established rapidly to prevent delays in support, patient's conditions deteriorating, waiting lists expanding (which increases delays and anxiety). • Holistic approach to condition • Pain management resources.	• Many pain services have stopped, leaving patients (e.g., with osteoporosis) to self-manage.

Fibromyalgia pathway

In the co-production group, we had several people with fibromyalgia. It became clear listening to their feedback that existing services had not met their needs. Their views on how services could have been delivered differently inspired one of the clinical facilitators to seek funding to develop a new pathway for patients with fibromyalgia.

The fact that people with fibromyalgia had been involved in identifying a need for a different approach was key to the success of the funding bid. One of the patients from the co-production group subsequently became a member of the steering group for the new pathway and has continued to influence the design.

People with fibromyalgia referred to the musculoskeletal service now follow a **new co-produced pathway** and to date there is evidence that it is both improving patient experience and clinical outcomes.

Two further studies are planned to evaluate the pathway which we anticipate will lead to further dissemination of the co-production model and new pathway.

'The team were really lovely and I felt they were really listening to us whilst we explained our individual problems and experiences.

I have learnt some valuable techniques to help manage pain…I have tried and tested them at home and for more days than usual have been able to manage flare ups'.

'I feel I have understood my fibromyalgia much better at these classes. It is the first time I have been to anything like this, I have had fibromyalgia for a long time, I feel it is very helpful and felt listened to'.

'The service provided is excellent… prior to referral I felt in despair as I felt unlistened to'.

Additional impact

The involvement in the co-production work has led to many other changes in the workplace of those clinicians who were involved in the group. Examples include:

- **Gaining funding for training for clinicians to gain a greater understanding of shared decision making and motivational interviewing**
- **The establishment of a co-delivered Improving Access to Psychological Therapies (IAPT) and MSK service**
- **Alterations to assessment templates and patient information to promote personalised care.**

Those involved in the group report that the knowledge they gained from listening to people in the co-production group continues to influence their everyday practice. We would strongly recommend that all MSK teams undertake implementing the co-production model with their local population.

Our co-production journey

The project was driven by enthusiastic clinicians who recognised the importance of co-production in developing services to meet the needs of patients with musculoskeletal conditions. There was excellent collaboration between clinicians to ensure the project was sustainable and impactful. The support of representatives from the Personalised Care Institute who had experience of delivering co-production sessions was invaluable. We would recommend that observation of an established co-production group would be essential for those new to this way of working.

The people on the musculoskeletal co-production group enjoyed and valued being part of the group particularly when we related the impact of their feedback and how we were trying to implement change in practice. It was also rewarding that use of the co-production model was a key factor in the success of the subsequent funding bid related to our project.

Key challenges mainly related to the membership of the group. Despite widespread advertising, the use of social media and the use of existing networks, there were low numbers of volunteers and attracting enough people to run a group successfully took some time. Once we felt we had adequate numbers of participants to run the group we did not feel we had enough representation from protected characteristic groups. We tried to address this during the project but with very limited success; this is something we would wish to focus on for any future co-production groups.

Additionally, we had people with different types of conditions in the group, for example those with very rare musculoskeletal conditions; patients with a diagnosis of inflammatory disease; people who were waiting for or who had undergone surgery; people with chronic pain. Whilst the group had many common themes each group also raised issues that were specifically relevant to their circumstances. As we were focussing on the very start of the musculoskeletal journey with people, this did not have too much of an impact, but we have discussed in the future would it be better to segregate groups particularly if considering effective service delivery post diagnosis.

Stakeholder engagement is key

Our co-production group consisted of musculoskeletal physiotherapists and people with musculoskeletal conditions and one third sector representative.

For the future we feel it would be beneficial to have greater stakeholder involvement across the community including wider third sector representation and colleagues across both primary and secondary care.