

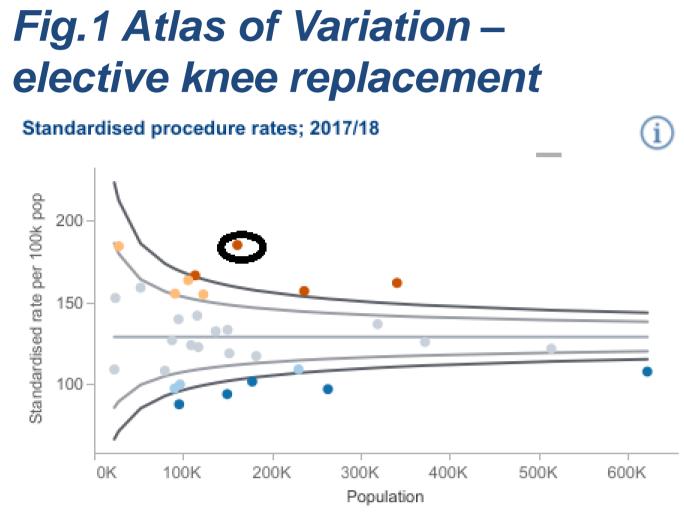
# A Best in Class Approach for Hips and Knees

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## **Big Aim**

By March 2021 all people in Forth Valley needing or at risk of needing services for hip and knee problems optimise their outcomes through a right time, right place prevention and recovery approach, reducing demand on formal services by 10%. The initial focus has been on a population of 50,000 in Clackmannanshire

What is the problem we're trying to solve? People with hip and knee problems routinely look for healthcare through GP consultation. Most degenerative joint problems do not need a GP to diagnose, or direct treatment. Forth Valley has increasing demand on GP, surgical and physiotherapy services. We have higher than average rate of knee replacements (Fig.1), lower than average age of surgery and variation between practices and practitioners in referral rates to both physiotherapy and orthopaedic services. Activity options are variably provided, disempowering people from managing their recovery. A proportion of people arrive for surgery unprepared and having missed necessary interventions, leading to cancelled operations. We are dissatisfied with the experience being provided to patients and aspiration to achieve "best in class" care and support.



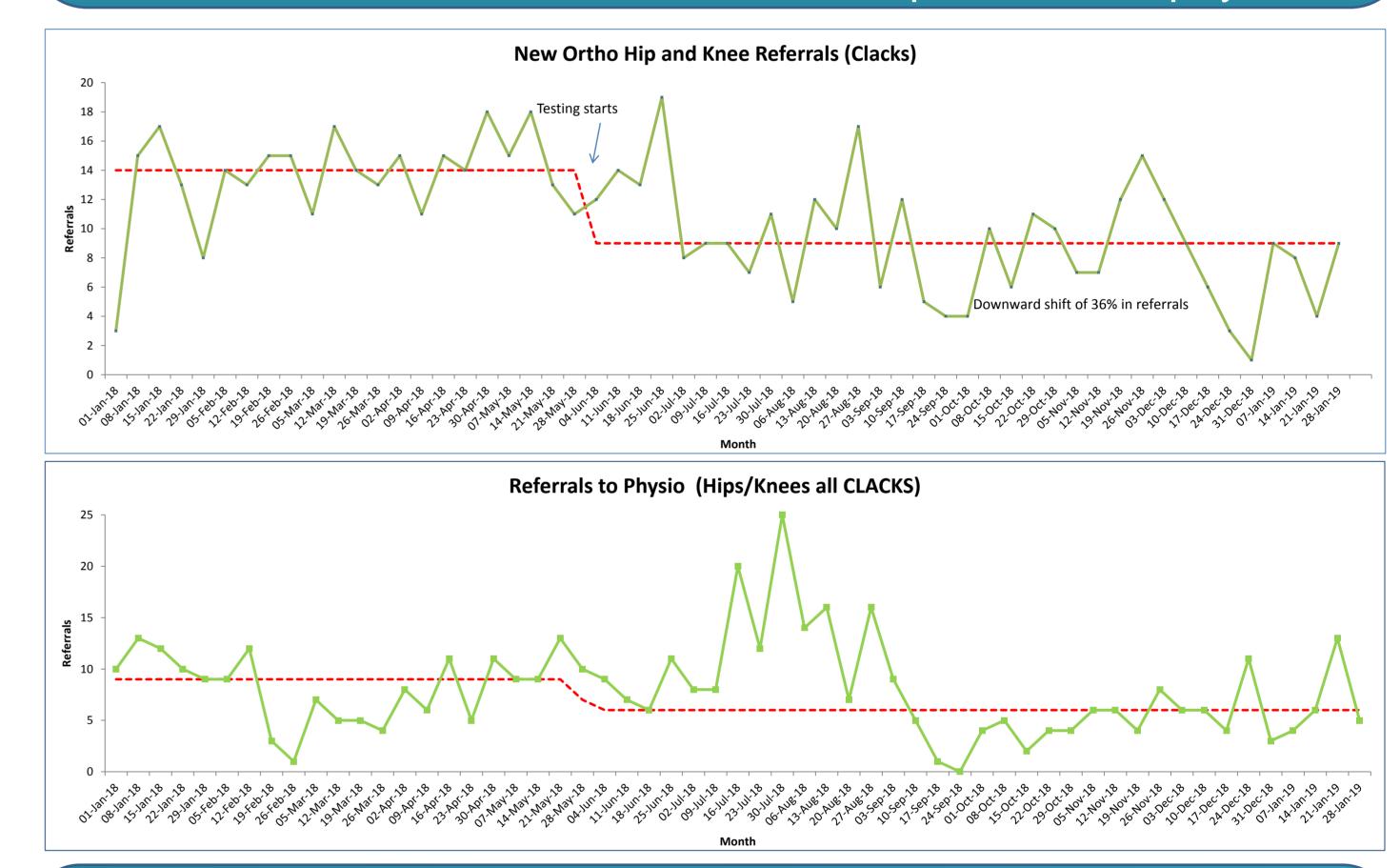
Best in Class lower limb #00INTLYin PV OVERVIEW DIAGRAM - November 2017 Reading left to right answers the question 'What changes can we make that will result in an improvement?' Reading right to left answers the question 'What are we trying to accomplish?'				
Model adapted from Reed at al. Overall aim	(2014), citing Langley Primary Outcomes	Process Outcomes	Interventions	Implementation activity Critical Factors
Morepeople manage - Lower Lank Joint Problems through a proactive recovery based pathway . Berate of referal to formal supports reduces – Physics / Orthopaetics //surgey	Propletable personal responsibility for the behaviour of factors contributing to their contributing to their contributing to their personal parameters posterior patients overred Printary Carrie posterior and person centred Prestitution and Carri- toward become making with people	Propile are procedurely informed and empowered to take control of their coun- condition Propile with joint pain follow the recovery pathway	no instrumentlight touch opportung to information and inductional incourance (imple andpress for themany investments and instruments approaches are themany improvements to the of particle Actuation toware Propies Actuation toware A Recovery focussed pathway is developed for everyonie seeking support (clock model) Non Medical Community based models of support are put in place as first point of support where assistance is sought. Medit Management is a preview inprovement are and support is autobase behavingapps, web based incouragetapps, web based	Public Motivation is consistently nudged - what helps keep joints healthy Lighten the Load -Choose to Lose Stay strong - Choose to Move Understand pain
Rowh The CLASE CARE		Chescales Interview Before surgical consideration Chescales, not incom approach through internation empowerment surgical referral is supported through therecomy pathough at the right time is not warred time. People are at not warred time. People are at new pathogating in recomy right up to surgery and beyond Chescales Interview		Staff are educated on Brief Intervention and Motivational Approaches Standardised, clear and accessible information and resources are identified and shared MATS, NHS Inform, Retrain Pain etc Clinicians have and are empowered to use evidence based information on risks, benefits and recovery options. "what matters to you" what is best for you"
	Non-medical models are always first consideration there is Reduced Variation and exce- action the care pathway			MSK Joint Advisor Approach is developed in Primary Care Social prescribing and Community based joint pain recovery Programmes are in place
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#### What is our strategy for change?

- A collaboration between hospital and community based health professionals, GP Quality Cluster and Local Authority funded activity providers
- Personal stories and user experience driving change from the start
- Practitioners' visions for best in class journeys shared in workshops
- Journey mapping using people's stories of challenges in getting "right support, advice and information"

#### **Outcome / Results**

In first 8 months the community support model has supported ➤at least 868 individuals.  $\rightarrow$  Joint Advisor New Assistance / Appointments = 488  $\succ$  Total assistance visits = 601 >Number attending the community exercise programme =160 >30% reduction in referrals to both orthopaedics and physic



- Tests of change designed by the team members using feedback
- 30/60/90 day plans and cycles of change used to keep momentum
- Monthly analyst/data meetings, meetings of local project team and community healthcare practitioners.
- New EMIS activity forms for GP data capture. MSKHQ, weight and BMI collected at the joint advisor clinics



#### **Principles**

Enable whole system ownership – no more silos

Not doing more – doing different

nproved outcomes for people - what matters to individual

Give choice and control – shared decision making

Understand variation and resource use across the pathway

Develop long term resilience – best in class mode

## What changes have we made?

- Direct access to a Physiotherapy Joint Advisor as first point of contact in primary care
- People redirected to advice clinics, weight management support and exercise options in community from formal referral pathways

Outcomes: Sample group of pre and post MSKHQ outcome measures from 89 people; >58 statistically significant improvement in score,  $\geq$  20 same or improved with non significant change, >13 worse than baseline (approx half of whom awaiting surgery)

> "Hip and Knee Exercise sessions improved my recovery immensely." "Info session very informative, separates myths from facts." "Information session has taken the fear out of exercising again." "Very useful info, makes things a lot clearer." "I'm Back to golf after Kenny's classes."

## **Conclusions and learning**

- Ready to scale up, but need to balance pressure to spread with ability to move at pace
- •Take all opportunities to integrate improvement e.g. primary
- Tested and marketed tailored direct access Hip and Knee activity ulletclasses
- Consistent tailored information
- Staff trained in 'good conversations', talking about weight as well as exercise and signposting to Choose to Loose web pages and weight management service
- Orthopaedic team tested post referral education sessions and optimising use of skills

care improvement planning, Realistic Medicine, adaptability of activity providers and seed funding

•Deep dive into demand and activity data enabled through 'advanced analytics' project with The Health Foundation

•Making good use of user needs led service design advice and training through Healthcare Improvement Scotland iHub project

 Bringing people working in silos and at full pace together in a protected space to understand problems, roles and data is a continuing challenge, but really satisfying

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