4 Weeks
Rapid Access to Allied Health Professional MSK

Working Paper
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1. Introduction

The Scottish Government defined the future vision for Allied Health Professionals (AHP’s) and the services they deliver in “The National Delivery Plan for Allied Health Professionals in Scotland, 2012 to 2015” [1]. One of the elements of this plan was the development of a National AHP Musculoskeletal (MSK) 4 Week Target. Significant redesign and transformation of Scotland’s Allied Health Professional (AHP) Musculoskeletal Services (MSK) has been on-going since 2010, with three MSK Early Implementer Boards – NHS Lanarkshire, NHS Ayrshire and Arran and NHS Lothian. NHS24 has also worked with each of the pilot Boards, specifically looking at demand side solutions through provision of a telephone Musculoskeletal Advice and Triage Service (MATS).

There are many drivers for continued MSK pathway and outcome improvement. AHP MSK services deal with high volume demand, currently presenting at 400,000+ referrals per annum. It is also estimated that between 20-30% of all General Practitioner (GP) consultations are for MSK complaints[2,3], with 10 million work days lost annually with MSK problems.[4] In addition, people with a MSK condition are the second largest group (22%) in receipt of incapacity benefit after people suffering from mental health conditions.[5] This presentation has significant costs for the individual, but also significant impact on a wider socio-economical scale. Orthopaedic activity is also high, with duplication across general practice, orthopaedic and AHP services, all providing opportunities for integration and new innovative team working.

Further progress is required to address the growing MSK demand, as well as variation in information, access, waiting times, intervention and outcomes. Introduction of the HEAT target (with associated data collection, performance and quality improvement) will make a vital contribution to timely diagnosis, faster investigations, earlier interventions in primary care and current orthopaedic referral to treatment standards.

This approach supports the NHS Scotland’s Quality Ambition (as described in The Healthcare Quality Strategy for Scotland) 6 to deliver world leading person centred, safe and effective healthcare service. It has particular focus on a number of priority areas within the 2020 Vision for Health and Social Care in Scotland and contributes across the Routemap. Working across the whole MSK pathway, AHP’s can offer, at general and advanced practice level, significant improvements in efficacy of MSK services, including improved outcomes and patient satisfaction.

The purpose of this paper is to provide guidance for Health Boards on:
- Target and Standard Principles and Definitions.
- MSK Minimum Dataset and Key Performance Indicators.
- Key elements of the improvement work

1.1 The AHP MSK 4 Week Target

From 1st April 2016, the maximum wait for AHP MSK Services from referral to first clinical out-patient appointment will be 4 weeks (for 90% of patients). First clinical appointment may be by telephone, video or face to face.
1.1.1 Definition of MSK:
The term musculoskeletal problems includes a diversity of complaints and diseases localised in joints, bones, cartilage, ligaments, tendons, tendon sheaths, bursa and muscles. MSK problems also include out-patient pre or post orthopaedic surgery, peripheral nerve lesions (e.g. carpal tunnel, sciatica) or complication of fracture/dislocation/trauma.

1.1.2 Inclusions:
Referrals to:
- AHP MSK
- Adults
- Where MSK is the primary reason for referral.
- Occupational Health AHP MSK Services
- In the following AHP MSK Professions only-

<table>
<thead>
<tr>
<th>Speciality Value</th>
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<tr>
<td>Physiotherapy</td>
<td>R5</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>R4</td>
</tr>
<tr>
<td>Chiropody/Podiatry</td>
<td>R1</td>
</tr>
<tr>
<td>Orthotics</td>
<td>RF2</td>
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* Note Prosthetics are excluded and Orthotic included. Two new speciality codes have been introduced Prosthetics (RF1) and orthotics (RF2) to be recorded separately.

** Note Podiatry- A list of MSK podiatry clinical conditions has been included for clarity as Appendix 1.

** Orthotics- Orthotists are autonomous registered practitioners who provide gait analysis and engineering solutions to patients with problems of the neuro, muscular and skeletal systems. Patients frequently present with co-morbidities but the focus of the treatment is almost always to improve neuro muscular skeletal performance. All orthotic referrals are therefore included in the target definition.

1.1.3 Exclusions:
Exclusions include:
- All other AHP professions
- In-Patients
- Domiciliary (home visit) patients
- Non NHS Funded patients.

Service exclusions:
- Specialist Chronic Pain services are excluded.
- Woman’s Health MSK services are excluded.
- Out-patient AHP Specialist rheumatology services are excluded
- MSK Children’s services are excluded

These service exclusions will be considered in a future phase.
1.2 AHP MSK Minimum Dataset (Key Performance)

The aim is to collect patient level data through the waiting times data warehouse. The data warehouse is a database hosted by ISD specifically designed to support analysis and reporting. This will allow measurement of performance for the 4 week target and other MSK key performance indicators.

A minimum dataset has been developed to support MSK redesign and transformation. Collection of a MSK information dataset will identify 4 week achievement and audit performance against the MSK Minimum Standards. It will also facilitate monitoring of MSK services and inform improvement requirements. It will also ensure that standardised tools are used systematically, allowing comparison of effectiveness, efficiency and sharing of good practice.

The minimum MSK AHP dataset includes the following key components:

Indicators calculated from the warehouse:
- MSK Waiting Time
- MSK Demand
- MSK Did Not Attend
- MSK Could Not Attend
- MSK New patient to return patient ratio

AHP Key Performance Indicator’s to be developed from other sources at a later stage:
- MSK Activity
- AHP MSK Injections
- MSK Outcomes PROM (EQ5D), Physical Activity Status, Employment Status
- Secondary Care Onward Referral
- AHP MSK Investigations- local
- Conversion to surgery rate-local
- MSK Slots Fill Rate-local

Illustration 1 - HEAT Target, Minimum Dataset, Key Performance Indicators

MSK 4 week target and Key Performance Indicator Data Set paper has been produced to be considered in conjunction with this paper.
1.3 The 4 Week Target Programme Structure

Some of the elements to achieve the 4 week target are already under development in Health Boards. Support and direction will be provided through Scottish Government Health Department (SGHD) and through the National MSK Lead Role and the MSK Programme Board. The work will sit under the Transforming Out-Patient Programme (TOPS) and utilise Collaborative methodology. In particular they will work closely with the Scottish Government Orthopaedic Service Redesign Group. A number of Task and Finish groups will lead key elements of the service redesign and transformation.

Illustration 2- Programme Structure

(1) The MSK Informatics Steering Group
MSK Informatics Steering Group representation is included as Appendix 2.

This group has overarching responsibility to support NHS Health Boards in meeting the information requirements for the 4 week AHP MSK 4 week target and associated minimum dataset. Further details on the role of the Information Strategy and delivery are included in Section 3 of this paper.

(2) The MSK Evaluation Group
MSK Evaluation Group representation is included as Appendix 3.

This group is responsible for providing evaluation and impact information on testing from pilot sites and other Boards.

(3) The MSK Board Lead Group
MSK Board Lead Group representation is included as Appendix 4.
MSK Lead members have been identified as the lead person in their Board delivering and supporting services involved in meeting the 4 week target. The Board leads will share learning on progress and performance information in relation to 4 week Developmental HEAT target progress and communicate locally on service redesign and transformation. They have an integral role to play in communication and leadership regarding service transformation and target achievement. They will also seek advice from clinical expert groups for specific opinion on areas where further clinical expertise is required.

2.1 Service Redesign and Transformation Strategy

In line with other HEAT Targets and Referral to Treatment Standards, the Improvement work will have three key strategic elements, that combined, will deliver on the quality improvements and 4 week target. The work will incorporate the Minimum Standards Framework and the Minimum dataset. These are as follows:

- **Service Redesign and Transformation Strategy**
  The improvement methodology and core elements of the MSK transformation are described below. Focus is required to make best use of current capacity and resource with a number of clinical and process changes, which include alignment of AHP MSK services.

- **MSK E-Health Strategy**
  Developing and using information and eHealth technology to report on access times and support the transformation strategy through introduction of electronic referral, referral management systems, electronic clinical records and electronic measurement of outcome and impact.

- **Performance Management Strategy**
  Clear targets and performance indicators are set in this paper and service improvement momentum will require to be maintained through 2013-2016. The focus is on the Triple Aim- population health, value for money and experience of care.

Anticipated benefits may include:

- Earlier diagnosis, prevention of chronic conditions and better outcomes for many patients (includes close working and potential beneficial impact on Chronic Pain Services).
- Reduced inequalities by addressing variation in waiting times between NHS Boards and across localities within Boards
- Reduced time off work, contributing to a healthier population and impacting on the economic burden of unemployment
- Reduced the time and resource in managing long queues for assessment and treatment and reduced secondary care waits
- Improving patient satisfaction through reduction in number of visits across MSK pathways and through the provision of consistent self-management and clinical management advice.
- Standardising data across Health Boards and AHP Professions will improve data quality. This in turn permits record linkages with other national data and when anonymous can be used for detailed audit and research improvement purposes.
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- MSK waiting times will be transparent to the public, other services and government, increasing public confidence and documenting the role AHPs play in wider treatment targets.

2.2 Improvement Methodology

A number of common improvement tools will be utilised to deliver the redesign and transformation including:

- Use of Minimum Standards Framework and Standard Definitions
- Lean methodology
- Demand, Capacity, Activity, Queue work
- Robust performance management- process and clinical pathways
- Support to enhance leadership, workforce, education and culture change required- IT, advanced practice, exit collaborations
- Robust Communication Strategy.

2.3 Redesign and Transformation - Key Elements

Spread and sustainability of the high impact changes from Early Implementer Boards will be core to delivering the transformation required. Further tests of change and spread will progress as MSK work develops. Impact and best sequencing is included in an impact paper and change package. Key work streams are described below:

- **Demand side solutions**
  - Developing a national self- management platform
  - Introducing a national self- referral model through a single point of access
  - Testing a telephone call handler protocol driven triage model

- **IT/ Referral Management**
  - Electronic Referral Management as standard–Electronic referral, diaries, patient tracking
  - Identifying efficient administration processes through an admin hub, including patient focused booking
  - Testing and implementing Reminder Systems

- **Clinical Pathways**
  - Evidenced based, person-centred pathways
  - Minimum Standards Framework
  - Ability for AHP’s to order and review investigations

- **Exit Route Solutions**
  - Developing Leisure partnerships
  - Employment/return to work central to pathways-WHSS
  - Developing MSK pathways into Specialist Pain services
  - Developing Mental Health pathways

- **MSK Minimum Data Standards**
  - Electronic clinical record and tracking
  - Electronic outcome measures
3. Information Strategy
3.1 Information Steering Group Role

The MSK Informatics Steering Group will:

In the Short Term:
- Scope patient level data required to measure the target and develop key performance indicators.
- Establish a pilot site to explore and develop 4 Week work and minimum dataset measurement—Completed September 2013.
- Lead a scoping exercise of current AHP IT data collection systems and position
- Agree changes where NHS Scotland Waiting Times Guidance is not appropriate for the MSK 4 week target.
- Explore options for reporting the MSK minimum dataset.

To support 4 week Target Implementation:
- Compile and publish the definitions of what constitutes a 4 week AHP MSK Target
- Lead the implementation of cost effective and user friendly means of recording and reporting patient access times relative to 4 Weeks AHP MSK, with associated minimum dataset.
- Create a reporting framework which demonstrates progress towards and adherence to the 4 week target.
- Be responsible for the testing and validating data quality and process.
- Inform the CHPO and others in respect to the progress on the target.
- Manage lessons from pilot testing and roll out to all Health Boards

In developing the target they will assess key elements of the performance indicators against the following criteria: Clear and Transparent; Measurable, Resilient, Patient Focused, Affordable.

Work will be progressed by this group to communicate and support Boards locally and also develop data warehouse capability to support the 4 Week target. Reporting arrangements will be on a monthly basis.

Benefits of data warehouse for AHP’s:
- House waiting times data and minimum dataset (to develop key performance indicators)
- Produce, publish and communicate quarterly reports
- Link with other information about the patient held in other data marts (eg A&E)
- Provide longitudinal analysis on people reusing AHP services for a variety of queries eg with the same problem, impacting on work status, activity levels.

Additional fields will be required to be added to the data warehouse to fully support KPI reporting. These include:
- NHS 24 as source of referral
- Body region
- Employment Status
- Contact type (face to face, video, telephone, email)
3.2 Target Definition and Booking Guidance

We recognise that it is important that NHS Boards, their patients and their clinical teams understand the parameters of the AHP MSK 4 week Target and Standard.

Preliminary work has been completed to describe Principles, Scope and Definitions for the target. Work is on-going with the Access Support Division SGHD, to develop new definitions where required. Data processes and definitions will be tested within two Health Boards.

Issues of clinical complexity and tolerance will be developed over the coming months.

3.2.1 Waiting Time Calculation

The Health Board in receipt of initial referral is responsible for ensuring that the patient is seen within 4 weeks from receipt of referral.

- **Clock Start** is the date when a referral is received from a patient or health or social care professional
- **Clock Stop** is the date of first clinical out-patient appointment (which could be by telephone, video-link or face to face).

We have worked with the Access Support Division SGHD, to provide definitions on what constitutes a telephone and video link appointment.

**AHP MSK First appointment may include:**
- Initial assessment and provision of definitive advice
- Start of treatment
- Provision of equipment
- Fitting of a device

Completed waits and ongoing waiting time information will be collected.

**Completed Waiting Times**- For patients who have had a clock stop during the reporting period. This information includes numbers seen and the time they have waited.

**Ongoing Waits**- Patients waiting for their first clinical appointment, as at a census point. This information will include numbers waiting and the time they have waited at the census point.
3.2.2 What is a Referral?
A referral is a request to a MSK healthcare professional, team or organisation to provide appropriate care for a patient. This may include referral from the following sources:

Illustration 3: Referral sources AHP MSK

3.2.3 Offer of Appointment
The 4 week target sets new challenges in providing a reasonable offer. AHP MSK services also often offer an opt-in model in terms of booking, as MSK can resolve in a short timescale. We will work with the Access Support team SGHD, to develop a definition of Opt In/Patient Focused Booking that supports the 4 week target timescales.

Provisional thoughts are that Health Boards should utilise patient focused booking and should immediately on receipt of referral, send out a letter asking the patient to contact the service within seven days. (opt- in). When they opt in, two different dates of appointment should be offered when speaking to the patient, when they call back- as per current NHS Scotland Waiting Times Guidance. This will be the two reasonable offers.

Reasonable Offer- as per NHS Scotland Waiting Times Guidance
A reasonable offer of appointment is the offer of two or more different dates of appointment with a minimum of seven days notice from the date of offer to the date of appointment as per NHS Scotland Waiting Times Guidance.

Short notice appointments (eg those offered in less than seven days). If the patient accepts such a date then this would be deemed a reasonable offer. However if the patient declines such an offer they must not be disadvantaged and two further offers must still be made.

Health Boards must ensure that patient additional needs are taken into account and that appropriate support is put in place as required when offering an appointment. Any identified additional needs should be addressed. Examples of ways patients can be supported is provided in the Additional Needs example table in CEL 33 (2012) 8. http://www.sehd.scot.nhs.uk/mels/CEL2012_33.pdf
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Urgent appointments, where these have been identified by clinical need are exempt from the reasonable offer timescale of seven days, however every effort must be made to ensure the appointment date is suitable for the patient.

Appointment Location
Appointment location will include out-patient AHP centres, and in patients own homes where the MSK clinical consultation is by telephone or video link.

Patient refuses
If the patient refuses a reasonable offer (ie two or more different dates of appointment), then advice on next steps should be sought from the relevant clinical team. As part of this process, systems should be in place to record relevant information.

On refusal of a reasonable offer a Health Board may:
- Inform the GP if the patient has self referred
- Refer the patient back to their referring clinician
- Reset the treatment time clock to zero if it is not reasonable or clinically appropriate to refer the patient back to their referring clinician.

A period of unavailability must not be applied in circumstances when the patient refuses a reasonable offer of appointment. Health Boards must inform the patient of the consequences of refusing a reasonable offer.

Booking Methods
Staff should utilise information included in “Effective Patient booking for NHS Scotland 9”.
[As detailed in CEL 33 (2012)]

3.2.4 Non-Attendance
If the patient does not attend an agreed appointment and has not given the Health Board reasonable notice (DNA), then advice on next steps should be sought from the clinical team to which the patient was referred. Systems should be in place to record relevant information.

Health Boards may refer the patient back to the referring clinician or in the case of self referral notify the GP. The date of the non attendance must be recorded.

3.2.5 Patient Unavailability
If the patient has accepted a reasonable offer of appointment but then gives the service reasonable notice that they will not attend the appointment, then advice on next steps should be sought from the clinical team. As part of this process, systems should be in place to record relevant information. The Health Board may reset the patients waiting time clock to zero, where it is reasonable and clinically appropriate to do so. This would be effective from the day the patient informs the Health Board that they cannot attend rather then the appointment date.

Health Boards are not required to reset the clock to zero. For example should a patient require an urgent appointment it is unlikely it would be considered reasonable to reset the clock to zero.
3.2.6 Veterans
Priority treatment for veterans should be as per CEL 08 (2008)\(^{10}\) should be included as part of the booking process. [http://www.sehd.scot.nhs.uk/mels/CEL2008_08.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2008_08.pdf)
Also refer to CEL 03 (2009)\(^{11}\) [http://www.sehd.scot.nhs.uk/mels/CEL2009_03.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2009_03.pdf)

3.2.7 Clinic Outcome
The clinic outcome is the information from the clinic that indicates the status of the patients waiting time clock.

A clinic outcome must be recorded for every new, return and DNA patient appointment.

A clinic outcome should also be recorded where a decision is made out-with a clinic setting that directly affects status of the patients waiting time clock.

Additional AHP MSK clinic outcomes require to be added to electronic systems to ensure whole system information is captured. (Please note clinic outcomes –which are used nationally as part of waiting times reporting are different from other clinical outcomes eg body part outcomes-Roland and Morris etc-used as MSK outcome measures). The clinic outcomes will reflect discharge routes from AHP MSK services and proposed list is detailed below.

- Discharged with advice
- Discharged – on hold
- Failed to complete treatment
- Advised to visit GP
- Referral to ESP (internal referral)
- Referral to Chronic Pain Class (internal referral)
- Referral to Pain Clinic (internal referral)
- Referral to Leisure – accepted by patient
- Referral to Leisure – declined by patient
- Referral to Equally Well – accepted by patient
- Referral to Equally Well – declined by patient
- Mental Health Pack offered – accepted by patient
- Mental Health Pack offered – declined by patient
- Referral to Mental Health – accepted by patient
- Referral to Mental Health – declined by patient
- Referral to Physiotherapy Group/ Class – accepted by patient
- Referral to Physiotherapy Group/ Class – declined by patient
- Referral to Rheumatology (internal referral)
- Supplied with Equipment and Discharged
- Awaiting surgical opinion

Technical solutions will be sought through the national Trakcare and other system groups to add AHP clinic outcomes and advice given to Boards on final decision.

3.3 Information Strategy - Partnership and Communication

The MSK Informatics Steering Group will work in partnership with other MSK and AHP work streams at Scottish Government level including those mentioned in 1.3. The
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anticipated benefits would be to minimise duplication, increase efficiency, develop consistent standards and approach across the AHP Services, minimise the impact of change on service delivery and patient care. These groups would be both consulted and informed and include:

- Scottish Government Directorate
- Scottish Health Boards
- Pilot site MSK Informatics Management Team (comprising of HB MSK Lead, eHealth Lead, Information Manager)
- Health Boards MSK Informatics Management Team (comprising of HB MSK Lead, eHealth Lead, Information Manager)
- ISD Data warehouse service manager, analyst and publications team
- AHP Directors Group
- NMAHP CCLG
- AHPFS
- NHS 24
- WHSS

The MSK Informatics Steering Group (MSK ISG) will inform stakeholders at regular point of progress of the project and ensure communication is maintained into business as usual. Stakeholders are those listed above and may include NES, HIS, AHPFS, Professional Bodies, Education, Patient, Social Service, GPs, Consultants, etc as appropriate.

Health Boards MSK Informatics Team will inform:

- The MSK ISG and other appropriate stakeholder of data changes required, problems regarding data capture,
- Their members of information to be cascaded e.g. Publication dates specific system issues etc and consult with them on data quality
- Consult & Inform system suppliers of specific system changes required to deliver the MSK Heat Target and KPIs.
- ISD will inform the MSK ISG and other appropriate stakeholder of data quality issues prior to publication, code changes, data warehouse changes or unavailability periods, problems regarding data capture, dates of monthly meeting

Methods of communication may include, face to face meetings, electronic meetings e.g. Videoconferencing, teleconferencing, Webex, ISD website, MSK website, email, published reports, minutes of meeting, risk register, conference presentations etc

Communications Plan
4. Performance Management

4.1 Capacity and Workforce planning
First steps in delivering the 4 week target, is by measuring the current baseline wait position in each Board for AHP MSK services. The 4 week MSK National lead and other improvement support will work with Boards to support understanding and to analyse and manage:

- Demand
- Activity
- Capacity
- Queue

This data will enable informed decisions when redesigning current services. The modelling work will also allow Boards to identify requirements to meet 4 weeks and calculate which redesign components will have highest impact for their local arrangements and population.

Baseline DACQ support work will be provided in June and July 2013. Beyond this the MSK National Lead will work with Health Board MSK Leads to develop MSK work plans.

4.2 Key Information Deliverables

- Develop data to be collected
- Sign off draft dataset and target definitions
- Pilot sites test data submission
- Scoping exercise to see what systems Boards have and what data they can provide
- Local Delivery Plan Guidance developed
- Boards start submitting data
- Develop Management Information, develop publication
- First publication (December 2014) – All Boards to be in a position to submit for all professions in inclusion by this date.

4.3 Key deliverables service improvement

- December 2014 First publication
- April 2014 Boards have MSK steering groups and MSK action plan in place
- 2014/2015 Boards demonstrate improvements towards 4 weeks
- 1st April 2016 – Full target delivery
5. Appendices

**Appendix 1**  
*Podiatry Inclusions*

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<tr>
<td>• Hallux Valgus, Hallux Rigidus, Lesser Toe Deformity, Avascular Necrosis, OA, Sesamoid, Kohler’s Disease, Equino Varus, Tarsal Coalition, Pes Cavus</td>
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<tr>
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<tr>
<td>• Ankle Injury, Instability, fractures, OA, Avascular Neurosis, Cuboid Syndrome</td>
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<tr>
<td>• Heel pain (Plantar fascitis, Haglund’s deformity, neurogenic), Capsulitis, Morton’s Neuroma, Metatarsalgia</td>
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| • Chronic Regional Pain Syndrome, Compartment Syndrome,  
• Systemic (congenital, gout) |
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Appendix 2
The MSK Informatics Management Group Representatives

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<tr>
<th>Name</th>
<th>Board</th>
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<tr>
<td>Senga Cree (Chair)</td>
<td>National Lead AHP MSK</td>
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<tr>
<td>Sarah Mitchell</td>
<td>Lead AHP NDP</td>
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<tr>
<td>Tracy McInnes</td>
<td>AHP Officer Education and Workforce</td>
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<tr>
<td>Angela Murphy</td>
<td>AHP Lead NHS Tayside</td>
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<tr>
<td>Lesley Holdsworth</td>
<td>NHS Health Improvement Scotland</td>
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<tr>
<td>Jamie Pearson</td>
<td>Access Team, Scottish Government</td>
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<tr>
<td>Amy McKeown</td>
<td>Principal Informational Analyst-ISD</td>
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<tr>
<td>Liz Mitchell</td>
<td>AHP Clinical Advisor, ISD</td>
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<tr>
<td>Fiona MacKenzie</td>
<td>Service Manager for Service Access, ISD</td>
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<tr>
<td>Katriona Sked</td>
<td>Information Management, NHS A&amp;A</td>
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<td>Stewart Hatrick</td>
<td>Business Intelligence Manager (Acute), NHS GG&amp;C</td>
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<tr>
<td>Martin McCoy</td>
<td>Senior Information Analyst ISD</td>
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<td>Peter McCrossan</td>
<td>AHP Associate Director, NHS Lanarkshire</td>
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<td>Stewart Cully</td>
<td>Assistant Information Services, NHS D&amp;G</td>
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<tr>
<td>Paul Woolman</td>
<td>Information Service Manager –Forth valley</td>
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<tr>
<td>Fiona Webster</td>
<td>Principal Information Development Officer -ISD</td>
</tr>
<tr>
<td>Stuart Wallace</td>
<td>Information Officer NHS Lanarkshire</td>
</tr>
<tr>
<td>Frances Paton</td>
<td>Business Intelligence Manager-NHS GG&amp;C</td>
</tr>
<tr>
<td>Catherine Meldrum</td>
<td>Health Records Systems &amp;DQ-NHS GG&amp;C</td>
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Appendix 3
The MSK Evaluation Group Representatives

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
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<tbody>
<tr>
<td>Ewan Macdonald</td>
<td>Professor, Head of the Healthy Working Lives Group, University of Glasgow</td>
</tr>
<tr>
<td>Senga Cree</td>
<td>National Lead MSK/HEAT Target</td>
</tr>
<tr>
<td>Dr Sarah Mitchell</td>
<td>National Lead. Rehabilitation</td>
</tr>
<tr>
<td>Dr. Lia Demou</td>
<td>Research Associate, University of Glasgow</td>
</tr>
<tr>
<td>Ms. Margaret Hanson</td>
<td>Principal Ergonomist, WorksOut</td>
</tr>
<tr>
<td>Ms. Joyce Craig</td>
<td>Craig Health Economics Consultancy Limited</td>
</tr>
<tr>
<td>Lesley Holdsworth</td>
<td>AHP Associate Director NHS 24 –now with Health Improvement Scotland</td>
</tr>
<tr>
<td>Janie Thomson</td>
<td>NHS Lanarkshire</td>
</tr>
<tr>
<td>Dr Vijay Sonthalia</td>
<td>Chair Lanarkshire LMC, Blantyre Health Centre</td>
</tr>
<tr>
<td>Tracey Howe</td>
<td>School of Health, Glasgow Caledonian University</td>
</tr>
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Appendix 4
The MSK Board Lead Group

<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td>Senga Cree</td>
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<tr>
<td>Billy McLean</td>
<td>NHS Ayrshire &amp; Arran</td>
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<tr>
<td>Sarah Mitchell</td>
<td>Scottish Government</td>
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<tr>
<td>Claire Pickthall</td>
<td>NHS Forth Valley</td>
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<tr>
<td>Helen</td>
<td>NHS Highland</td>
</tr>
<tr>
<td>Fiona Smith</td>
<td>NHS Shetland</td>
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<tr>
<td>Wendy Johnson</td>
<td>NHS Lothian</td>
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<td>Eddie Balfour</td>
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<td>Janie Thomson</td>
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<tr>
<td>Judith Reid</td>
<td>NHS Ayrshire &amp; Arran</td>
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<td>Angela Murphy</td>
<td>NHS Tayside</td>
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<tr>
<td>Janice Miller</td>
<td>NHS Greater Glasgow &amp; Clyde</td>
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<tr>
<td>Kathryn MacPherson</td>
<td>NHS Waiting times Board</td>
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<td>Luz Salazar</td>
<td>NHS Western Isles</td>
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<td>Peter MacKellar</td>
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<tr>
<td>David Wylie</td>
<td>NHS Greater Glasgow &amp; Clyde rep Podiatry</td>
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<tr>
<td>Lynn Morrison</td>
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<tr>
<td>Shelagh Kingstree</td>
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<tr>
<td>Grant Syme</td>
<td>NHS Fife</td>
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<tr>
<td>Fraser Ferguson</td>
<td>NHS 24</td>
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<tr>
<td>Chris Rowley</td>
<td>NHS Greater Glasgow &amp; Clyde rep Orthotics</td>
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<tr>
<td>Amanda Jones</td>
<td>NHS Lothian rep Occupational Health</td>
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<tr>
<td>Carol Kirk</td>
<td>NHS A&amp;A rep Occupational Therapy</td>
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<td>Colin Redmond</td>
<td>NHS Borders</td>
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<tr>
<td>Gillian Borthwick</td>
<td>Scottish Government-TOPS Programme</td>
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<tr>
<td>Janice McNee</td>
<td>NHS Tayside- GP Decision Tool</td>
</tr>
<tr>
<td>Ruth Currie</td>
<td>NHS Lanarkshire</td>
</tr>
<tr>
<td>Val Blair</td>
<td>NHS Education for Scotland</td>
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6. References


