

Allied Health Professional (AHP) Musculoskeletal Pathway Framework (National Minimum Standard)

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Foreword

This document contains a national minimum standards framework applicable to Allied Health Professional (AHP) Musculoskeletal (MSK) Services across Scotland. The purpose of the document is to ensure that people requiring MSK services, receive the quality of care and the support they require, at the appropriate time by the appropriate person.

The framework has been developed by a group of MSK clinicians, originally providing a framework back pain pathway, which has further evolved to a minimum standard framework for AHP Musculoskeletal pathways. The need for separate work has been identified to define and develop AHP pathways for patients requiring early onward specialist assessment in Rheumatology (inflammatory disease) and to link closely with this and the national work relating to chronic pain standards and services.

Musculoskeletal conditions have been defined as problems to include a diversity of complaints and diseases localised in joints, bones, cartilage, ligaments, tendons, tendon sheaths, bursa and muscles.

The aim of the framework is to reduce the variance within MSK service provision and facilitate delivery of key quality policy directives, in particular the triple aim in the 2020 Vision of quality care, value and sustainability and a healthy population.

AHP's working in close collaboration with medical and other colleagues is absolutely necessary to improve Musculoskeletal services. The National Standards will provide a focus on the clinical pathway, the process and a supported clinician. Application of the framework will provide consistency of approach and consistency of outcome and also act as a facilitator for the AHP MSK 4 week target.

Senga Cree

National Lead MSK Pathways/ MSK Waiting Times

1. Introduction

It is estimated that between 20 to 30% of all General Practitioner (GP) consultations are about musculoskeletal complaints^[1,2], with spinal and soft tissue disorders within the top ten of conditions ranked by annual contact rates per 1000 practice population^[3]. Musculoskeletal conditions are associated with the worst quality of life scores compared with a myriad of conditions, including mental health, cardiovascular and respiratory diseases, visual and hearing impairment renal disease and cancer^[4]. Some 10 million working days are lost on average per annum through musculoskeletal problems^[5] and musculoskeletal patients are the second largest group of patients (22%) in receipt of incapacity benefits after patients suffering from mental ill-health^[6]. Orthopaedic activity is high and continues to increase with activity growing in some countries in the region of 12 per cent in ten years for both inpatients and outpatients^[7]. Elective joint replacement surgery is predicted to rise by 4.2% per year^[1]. The number of people in Scotland having hip and knee joint replacements has grown from 7,000 to 15,000 in the last 10 years. The cost in Scotland for orthopaedics has risen from £180 million 1999/2000 to £360 million in 2007/8^[8]. Possible causes for the rise in activity includes the ageing population and increased longevity^[9], expansion of new procedures and technology in orthopaedics^[10], obesity and increased use of alcohol^[11], perceived increased patient demand due to a greater awareness of diagnostic and therapeutic advances^[12]. In 2007 it was estimated that the total cost to society of musculoskeletal conditions was in the region of £7 billion^[13]. With this increased activity it is estimated that the demand for Trauma and Orthopaedic surgeons will overtake supply in the next five to ten years^[11].

Policy initiatives to improve the patient experience, for example the 18 week Referral to Treatment Standard^[14], Shift in the Balance of Care agendas^[15,16], and also to respond to socioeconomic pressures, for example the European Working Time Directive^[17], the limitation of junior doctors hours^[18], changes to the General Practitioner (GP) and Consultant contracts^[19,20], and the financial pressure on public services^[21]; have put further pressure on services to redesign or reconfigure traditional musculoskeletal services.

These demands on future services have been further compounded by the rise in complexity and sub specialisation of trauma and orthopaedic surgery^[11], the reduction in orthopaedic spinal surgeons (owing to changes in medical training, perceived low success of spinal surgery and reduced opportunity for private income)^[22], the increased feminisation of medicine^[23] and the increased litigation culture^[24]. Rising GP referral rates to acute services^[25] have also been suggested as a possible contributing factor to altered referral thresholds possibly owing to guideline implementation^[25], disgruntlement at the lack of access to other services, for example physiotherapy^[26], or increasing clinical diagnostic uncertainty^[27].

Policy makers and clinicians have searched for innovative ways to try and cope with increasing demand for musculoskeletal services^[1,28]. While the intent of many of these innovations are often admirable they are commonly introduced unilaterally and locally, leading to widespread unnecessary national variation^[8] between health boards and even within the same health board. This variation results in a 'post code lottery' of care for those with musculoskeletal conditions in the National Health Service (NHS) Scotland^[29].

It has been estimated that between 10% to 40% of new orthopaedic referrals do not require a surgical opinion and of patients on a waiting list, between 5% and 15% do not want or need surgery^[30]. It has therefore been considered important that General Practitioners (GPs), orthopaedic services and AHP services work in unison to ensure that referrals are appropriately reviewed to ascertain which patients require acute hospital referral and those patients who could benefit from rapid access to more locally based community services^[28,31].

Many healthcare services have acknowledged the expertise of AHPs with extended roles and reconfigured their services to incorporate AHPs into patient management models working in collaboration with the medical team^[32,33,34].

The idea of AHPs supporting orthopaedic services is not new. The concept was thought to be first reported in the United Kingdom (UK) by Byles and Ling^[35]. These authors noted the increasing rise in surgical workload of orthopaedic surgeons and suggested that a physiotherapist could effectively see many patients who required conservative orthopaedic management. This was backed up by numerous studies highlighting that many patients who were referred to orthopaedic outpatient departments either failed to attend (often because their condition had improved), were referred for physiotherapy or a simple appliance, or received treatment that they could have received from a general medical practitioner^[36,37,38]. Historically it was estimated up to 60% of all referrals to an orthopaedic outpatient clinic could be managed safely by a physiotherapist and to the satisfaction of most patients^[35]. The subsequent introduction of physiotherapists undertaking musculoskeletal extended scope roles termed Extended Scope Physiotherapists (ESPs) or Advanced Practitioners has been widely regarded as a positive development^[32,35,39,40,41] and anecdotally successful^[42,43]. Other AHPs have followed suit in developing advanced practice roles.

In Scotland the term Advanced Practitioner has now been used to encompass the work of ESPs and also the extended/enhanced work of other AHPs. Advanced AHP Practitioners have been defined as "experienced professionals who have developed their skills and theoretical knowledge

to a very high level which is supported by evidence. They perform a highly complex role and continually develop practice within Musculoskeletal Services”^[44].

All Health Boards in Scotland have developed their services to incorporate these advanced practice roles to varying degrees, acknowledging the expertise and efficiency that they bring to delivering services fit for the future. These roles are proving critical to the development and delivery of evidence based pathways of care. This document marks the start of a journey towards reducing unnecessary variation in musculoskeletal care by outlining a minimum standard framework for the management of MSK conditions across NHS Scotland.

2. Musculoskeletal (MSK) Pathway Framework - (National Minimum Standard)

The Musculoskeletal (MSK) Pathway Framework is shown in Figure 1 and the individual components outlined in the following sections of this document. The term framework is used as each health board will have some necessary variation in musculoskeletal pathway delivery depending on historical investment in musculoskeletal services, management structures, skill mix, facilities, geography, socioeconomic factors and variation in local orthopaedic specialties and links with tertiary services. It is intended, however, that this framework will be the beginning of a process to reduce the variation.

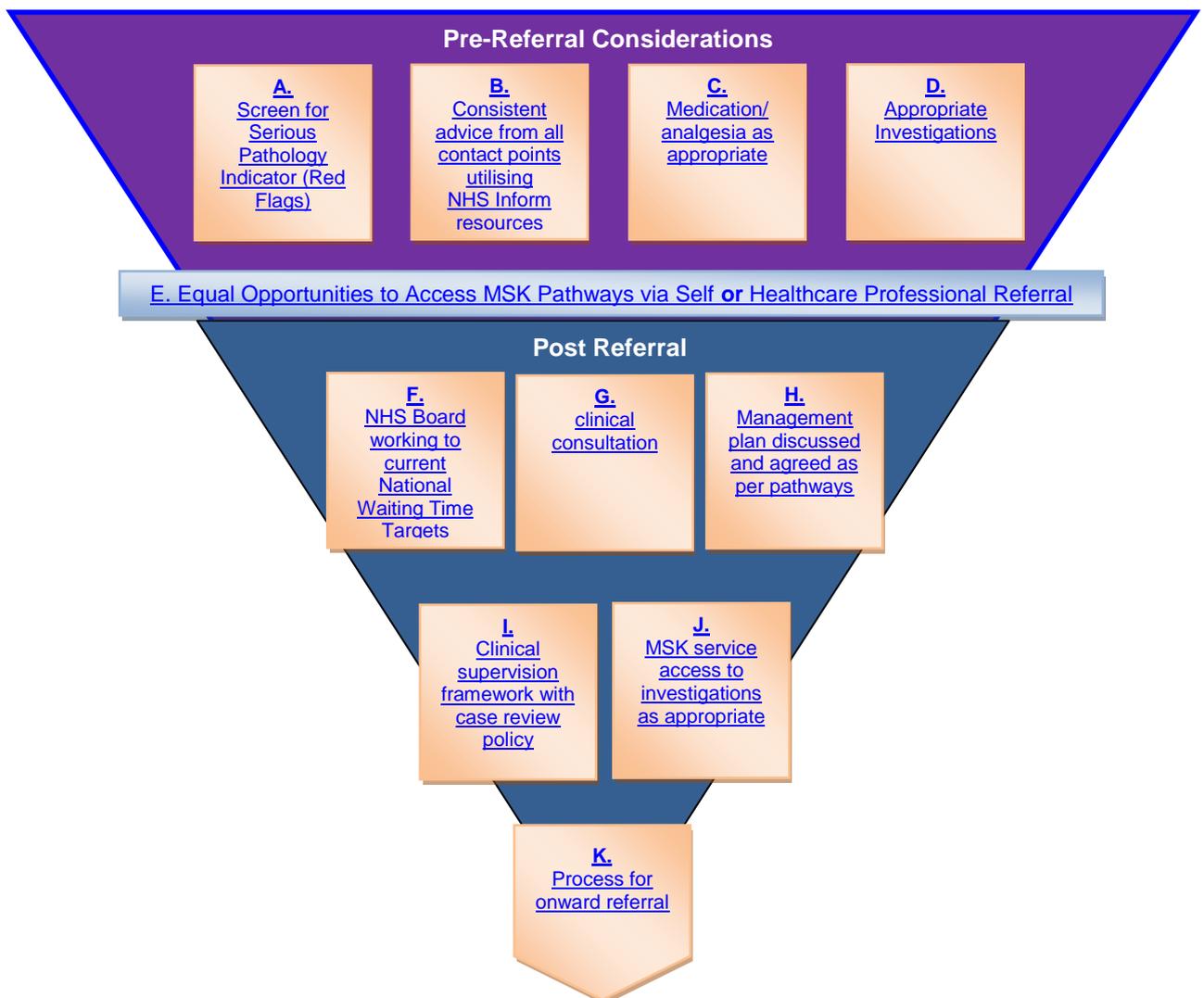


Figure 1: Musculoskeletal (MSK) Pathway Framework - (a Minimum Standard)

PRE REFERRAL CONSIDERATIONS

A. Screen for Serious Pathology Indicators (Red Flags)

NHS Scotland is focussed on improving quality, addressing excessive variation in practice, and ensuring the highest standards of patient safety^[45]. It is therefore imperative to identify conditions or co-morbidities that may deter a patient's recovery and function or place the patient at risk for serious medical consequences^[46]. The clinician must remain alert to potential clinical indicators that require more extensive testing than that afforded by a basic clinical examination^[47]. The term 'red flags' refers to clinical features that may be associated with the presence of a serious, but relatively uncommon conditions requiring urgent evaluation. Such conditions include tumours, infection, fractures and neurological damage^[48].

Screening for serious conditions occurs as part of a history and physical examination and should occur at the initial assessment and subsequent visits^[49].

Rather than recording an exhaustive list of serious pathology indicators (red flags), clinicians should consider a small numbers of disorders in which early diagnosis might make a large difference (i.e. cauda equina syndrome, major intra-abdominal pathology, focal infections, and fractures)^[50] and cancer^[48]. Examples of common serious pathology/red flag indicators for low back pain are shown in Table 1.

Table 1: Serious Pathology Indicators/ Red Flags for Low Back Pain^[48,51]

<ul style="list-style-type: none">• Sphincter disturbance• Saddle anaesthesia around anus, perineum or genitals• Progressive motor weakness in the legs or gait disturbance not due to leg pain• Difficulty with micturition not associated with medication
<ul style="list-style-type: none">• First episode of back pain less than 20 or greater than 50 years of age• Non mechanical pain• Violent trauma• Previous history cancer, steroids, drug abuse, osteoporosis• HIV, systemically unwell, weight loss• Structural deformity/height loss• Thoracic pain• Widespread neurology• Previous history of cancer + new onset Low Back Pain (LBP) + no improvement with 4 weeks conservative management• Night pain - (e.g. sleeping in chair, 'pacing' the floor')

Standard A

Screen for Serious Pathology Indicators (Red Flags)

Serious pathology indicator/red flags to be agreed and evidence of dissemination to all members of the musculoskeletal team documented.

B. Consistent Advice from All Contact Points Utilising NHS Inform Resources

A large body of evidence consistently indicates that patients who gain knowledge and skills improve their ability to manage self-care, enhance decision making and improve their quality of life^[52,53,54]. For some conditions, such as neck pain^[55,56] and shoulder pain^[57], there is evidence that supplementation of physiotherapy exercises with manual therapy may be of additional benefit, for other conditions such as osteoarthritis the main recommended treatment is advice about maintaining physical activities and provision of a structured exercise programme^[58]. Furthermore, the consensus of evidence suggests that supporting self-management can have benefit in the following areas: people's attitudes and behaviours, quality of life, clinical symptoms and use of health care resources^[54,59]. NHS Inform has a current work programme that is developing a range of web based enhanced information, advice and self management options for MSK conditions. This also includes the option to supply appropriate exercise regimes. Musculoskeletal services should promote and provide service users maximum opportunity to access and benefit from these extensive resources.

Standard B

Consistent Advice from All Contact Points Utilising NHS Inform Resources

NHS Inform resources to be made available to all members of the musculoskeletal team and evidence of dissemination documented.

Service User Information and related resources to be available to all members of the musculoskeletal team on common musculoskeletal conditions.

C. Medication / Analgesia as Appropriate

Acute and chronic pain are significant problems in musculoskeletal disorders^[60]. Pain is the most common symptom that causes patients to seek the help of health professionals^[61]. Many service users seek advice and treatment for acute episodes of self-limiting pain, but many others experience ongoing discomfort^[62]. It is estimated that approximately 50% of those with chronic pain have a musculoskeletal problem^[63]. The World Health Organisation (WHO) analgesic three-step ladder was developed for the management of pain associated with malignancy^[64], but many of its general principles can be applied to musculoskeletal pain^[62]. The benefits and risks of medications, in acute and chronic pain, are complex and probably dependent on the type and duration of the condition, underlying pain mechanisms involved and co-morbidities^[65,66]. Nevertheless, appropriate analgesia has the potential to ease pain, and reduce disability^[67,68]. Furthermore, appropriate pharmacological treatments are either the treatment of choice or a useful adjunct to non pharmacological therapies, for example in neuropathic pain conditions^[69,70,71,72]. An appropriate systematic pain history will

help determine the mechanisms producing pain and factors influencing the painful experience^[73]

Table 2: Pain history P Q R S T Approach^[73]

- **Precipitating/Alleviating Factors:**
What causes the pain? What aggravates it? Has medication or treatment worked in the past?
- **Quality of Pain:**
Ask the patient to describe the pain using words like “sharp”, dull, stabbing, burning”
- **Radiation**
Does pain exist in one location or radiate to other areas?
- **Severity**
Have patient use a descriptive, numeric or visual scale to rate the severity of pain.
- **Timing**
Is the pain constant or intermittent, when did it begin, and does it pulsate or have a rhythm

**Standard C
Medication / Analgesia as Appropriate**

Consistent advice on the use of medications in acute and chronic musculoskeletal conditions to be made available to all members of the musculoskeletal team, including the use of the World Health Organisation analgesic ladder.

D. Appropriate Investigations

The Scottish Government National Access Policy aims to ensure consistency of approach in providing access to services^[74]. It advocates that wherever possible patients should be referred for **appropriate** diagnostic tests **prior** to the referral being made for the first outpatient appointment^[74]. It has previously been estimated that at least 30% of patients attend an orthopaedic outpatient clinic either to find the ‘cause’ of their pain or to discover that there is nothing ‘seriously wrong’ with them^[36]. If these expectations can be addressed to the satisfaction of service users, this will reduce these inappropriate demands on musculoskeletal services.

The purpose of pre-referral investigations is to inform whether or not referral is required and to make the most appropriate use of AHP and medical services. There is a clear link here to Standard J.

**Standard D
Appropriate Investigations**

If indicated, appropriate diagnostic tests should be carried out prior to any referral being made.

E. Equal Opportunities to Access Musculoskeletal Pathways via Self or Healthcare Professional Referral

In the United Kingdom (UK) health service, patients with a musculoskeletal problem usually consult in general practice initially^[75]. Many patients are referred to physiotherapy^[75]. Providing timely access to physiotherapy has been a long standing problem in the NHS, with waiting times of several weeks or months for access in many areas of the UK^[76]. Waits for assessment, advice and appropriate management can result in patients' problems becoming chronic which may have consequences for their health and wellbeing^[77] and for the economy^[78]. Conversely, prompt and timely treatment and/or advice may mean that individuals are able to remain at, or return to, work whilst receiving treatment or return faster with more prompt management by NHS Allied Health Professions (AHP) services. In recent years, however, access has been improving and the efficacy for patient self-referral established^[79,80,81,82,83,84], under the right circumstances^[85]. During this time examples have also emerged of physiotherapists offering initial assessment and advice by telephone and web technologies using algorithms with self-management and/or face to face treatment options, where necessary^[75,86]. Early research findings around telephone assessment and advice services for patients with musculoskeletal conditions are promising, although require further evaluation^[75,86]. The vision would be to widen these opportunities and modes of access for patients, if appropriate.

Standard E

Equal Opportunities to Access Musculoskeletal Pathways via Self or Healthcare Professional Referral

AHP services should provide evidence that they are working towards self referral, where appropriate.

POST REFERRAL CONSIDERATIONS

F. NHS Board Working to Current National Waiting Time Targets

The National Delivery Plan for Allied Health Professionals (AHPs)^[74] defines the future vision for AHPs and the services they deliver. In doing this, it focuses specifically on a number of high-level outcomes that AHP services will effect, with key actions defined^[74]. Given the significant variation in musculoskeletal referral rates and waiting times across Scotland^[87] NHS boards will therefore be expected to deliver a maximum wait of no more than 4 weeks for AHP musculoskeletal treatment^[74]. The Scottish Government will thereby work with NHS

Boards on a developmental HEAT target to reduce Musculoskeletal AHP waiting times - with detailed target definitions to be agreed^[87].

Standard F
NHS Board Working to Current National Waiting Time Targets

AHP services should provide evidence that they are working to National Waiting Time targets.

G. Clinical Consultation

For a number of patients access to AHP services will continue to include referral from a GP and a clinical consultation with an appropriately qualified health care professional. We are, however, living in fiscally constrained times^[21]. The NHS in Scotland, similar to the rest of the UK is being challenged to provide high quality, safe and timely access to the right services with greater efficiency and improved productivity. It has never been so important and timely to establish appropriately responsive and acceptable clinical and cost effective modes of access for the benefit of patients, their carers, NHS Scotland and the wider societal economy. Advances in technology continue to provide real and feasible solutions to such challenges^[8]. Access to a range of AHP services need to be explored and NHS 24 is committed to exploit available technology in support of this and improving access to MSK services represents the first consideration in what is seen as a portfolio of service developments. Therefore telephony platforms and other IT resources may be used in the provision of clinical assessment and management of musculoskeletal conditions.

Standard G
AHP Services Will Provide Timely Clinical Consultation

AHP services should provide one to one clinical consultation within an appropriate timeframe which may not necessarily be face to face.

H. Management Plan Discussed and Agreed as per Pathways

The European Pathway Association (2007)^[88] defines care pathways as “a complex intervention for the mutual decision making and organization of predictable care for a well-defined group of patients during a well defined period”. Characteristics of care pathways include:

- An explicit state of the goals and key elements of the case based on evidence, best practice and patient expectations;
- The facilitation of the communication, co-ordination of roles and sequencing the activities of the multi-disciplinary care team, patient and their relatives;
- The documentation, monitoring and evaluation of variances and outcomes and the identification of the appropriate resources;
- The aim of a care pathway is to enhance the quality of care by improving patient outcomes, promoting patient safety, increasing patient satisfaction and optimising the use of resources⁽⁸⁹⁾

When developing a pathway one needs to take into account the evidence based key interventions, the interdisciplinary team work, service user involvement, and the available resources^[90]. Care pathways are a concept to introduce patient-centred care^[90]. Every patient is unique, but they should have enough in common to ensure care pathways are a useful norm, and patient and clinicians are able to make choices that differ from these pathways as needed^[91] As Kravitz and Melikow (2001)^[92] commented “most patients want to see the road map, including alternative routes, even if they don’t want to take over the wheel”. Goal setting is considered key to patient centred care^[93] and thus integral to pathway management. Goal setting is specifically outlined in the Health and Care Professions Council (HCPC) Standards of Proficiency for AHPs (2012)^[94] Table 3.

Table 3: Goal Setting^[93] [Physiotherapists]

2b.3 Be able to formulate specific and appropriate management plans including the setting of timescales:

- understand the requirement to adapt practice to meet the needs of different groups distinguished by, for example, physical, psychological, environmental, cultural or socio-economic factors;
- be able to set goals and construct specific individual and group physiotherapy programmes
- understand the need to agree the goals, priorities and methods of physiotherapy intervention in partnership with the service user;
- be able to apply problem solving and clinical reasoning to assessment findings to plan and prioritise appropriate physiotherapy;
- be able to select, plan, implement and manage physiotherapy treatment aimed at the facilitation and restoration of movement and function.

Professional conduct means adhering to professional regulations^[95]. As such, the purposes of goal setting has been identified as to meet contractual, legislative and or professional requirements, and to either improve outcomes or evaluate them^[96].

A goal is an intended future state; this will usually involve a change from the current situation although, in some circumstances maintenance of a current state in the face of expected deterioration might be a goal. Second, and of equal importance, a goal refers to the intended consequence of actions undertaken by the clinician(s)^[97].

NHS Boards should define and implement clearly defined pathways with agreed goals, with patients, for the most common musculoskeletal conditions. Pathways, however do need to be developed locally, for adopting pathways without translating them and adapting them to specific organisations and teams could be unsafe and ineffective^[90].

Standard H
Management Plan Discussed and Agreed as per Pathways

NHS Boards to clearly define their referral pathways from primary to tertiary care for common musculoskeletal conditions e.g. low back pain, knees.

AHP services to provide evidence of patient centred goal setting.

I. Clinical Supervision Framework with Case Review Policy

Goal setting is not, nor should it be, a simple prediction of what will happen; it should be the intended result of some intervention(s)^[97]. Moreover, efficiency has been deemed one of the domains in a quality health service^[98,99]. If patients are not deemed to be progressing towards the coproduced and agreed goals in the intended manner then it is important that reasons for this are explored and appropriate intervention implemented. Integral to this process is clinical supervision and a case review policy or standard operating procedure. Clinical supervision has been defined “as a collaborative process between two or more practitioners of the same or different professions”. This process should encourage the development of professional skills and enhanced quality of patient care through the implementation of an evidence-based approach to maintaining standards of practice. These standards are maintained through discussion around specific patient incidents or interventions using elements of reflection to inform the discussion^[100]. Three main functions of supervision have been identified: educative, supportive and managerial^[89,101]. Clinical supervision is not fieldwork/clinical education, mentorship, appraisal/development review, peer review, counselling or preceptorship^[100].

The 4S model of supervision – structure, skills, support and sustainability – is an example of one model which is intended to help professionals reach excellence in their practice^[102]. The embedding and sustaining of supervision schemes is a challenge in MSK services but they should be seen as integral to a culture of learning within developing services. Supervision should be career long, regular, routine and evaluated^[103].

To ensure that any clinical supervision policy/standard operating procedure is purposeful to promoting a quality and efficient service it should include a specific *case review or escalation procedure* for patients not progressing within an agreed time frame and over 3 review sessions (The average number of physiotherapy contacts in the UK is 3)^[104]. The procedure may outline the process for a telephone discussion and/or face to face discussion with an experienced colleague or other health care professional.

Standard I Clinical Supervision Framework with Case Review Policy

AHP services to have a clearly defined and documented supervision and case review policy/standard operating procedure with evidence of its use.

J. Musculoskeletal (MSK) Service Access to Investigations as Appropriate

NHS Education Scotland (NES) (2012)^[44] outlined the role of Advanced Practitioners in relation to advanced musculoskeletal practice. An example of one of the core knowledge and skills in relation to the requesting of investigations such as imaging is shown in Table 4.

Table 4: Advance Practice Framework Clinical Practice – Investigations^[44]

Pillar of Practice 1: Clinical Practice

- request relevant investigations within the scope of their practice and where they are the most appropriate person to make the request in the specific clinical context - requiring:
 - advanced knowledge of the role of investigations in facilitating a diagnosis,
 - the limitations of the information generated by the investigation, including sensitivity and specificity of tests involved, and
 - knowledge of the legislation, indications and contraindication of the investigation.

Evidence suggests that there is widespread variation in the extended practice of non medically qualified staff with regard to access to investigations, scope of practice, follow up procedures, training; competencies and clinical governance arrangements^[43,105,106,107,108]. Advanced Practitioners are, however, making significant contributions to musculoskeletal pathways in many areas, especially in areas such as in the management of spinal conditions^[109]. Given that this contribution is currently happening in some areas and not others, then greater consistency needs to be implemented. Provided that robust and consistent clinical governance arrangements are place, then AHP musculoskeletal services should be able to access the necessary tools and investigations when undertaking roles previously done by medical staff. This practice also ensures that patients are not disadvantaged by seeing a non medically qualified clinician.

Many services have reported positive outcomes using Advanced Practitioners in terms of reductions in orthopaedic outpatient waiting times^[34,110], professional development for the physiotherapy profession^[40,111], satisfactory patient management compared with orthopaedic surgeons^[112,113,114,115], improved communication between physiotherapy and orthopaedic services^[39,116], good patient satisfaction^[32,33,34], reduction in use of investigations compared to junior medical personnel^[32], freeing up of surgeons' time from outpatient clinics^[33], and for increased operating^[34,117].

The rules surrounding the legal standing of extended scope physiotherapy practice are complex^[118,119]. The General Medical Council (GMC) code of practice (2001)^[120] states, "When you delegate care or treatment you must be sure that the person to whom you

delegate is competent to carry out the procedures or provide the therapy involved”. However, the CSP Scope of Practice (2008)^[104] document stated “Non-medically qualified staff who hold a registrable qualification and have undertaken to perform a medically delegated task are responsible for the consequences of performing the task which can be reasonably expected to be within their competence. Advanced practitioners are accountable for their actions done to the patient.” Professionals are accountable to their regulatory body for all their professional activities, whatever the level and context of their practice, the title they can use or type of activities they can undertake^[121]. Providing that there is evidence of an individual’s competence to undertake the role/activity in question and that the activity sits within the remit of their professional body the individual would be covered by their Professional Liability Insurance (PLI) as working within the scope of the profession^[104] and are working to the standard set by The Health and Care Professions Council.

Regulation has been defined as “The set of systems and activities intended to ensure that healthcare practitioners have the necessary knowledge, skills, attitudes and behaviours to provide health care safely”^[1]. It is, however, the responsibility of the employer to ensure that the creation of any new or extended roles comes with appropriate support and performance management mechanisms^[122]. Hence it is imperative that both clinicians and management know what the scope and expectations of the role are and the clinical governance arrangements of the service are clearly defined and documented^[106]. Frameworks and defined competencies for clinicians taking on advanced physiotherapy practice roles are available^[123]. Services should ensure they have robust clinical governance and service infrastructure in place to support AHP Advanced Practice roles. Clinical governance being defined as “a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”^[124].

Standard J

Musculoskeletal (MSK) Service Access to Investigations as Appropriate

AHP Advanced Practitioners/Extended Scope Practitioners should have a documented clinical governance infrastructure, competencies and standard operating procedures in place to allow independent requesting of appropriate investigations.

K. Process for Onward Referral

AHPs have clinical autonomy to best manage their patients. AHPs should be able to refer their patients to the appropriate clinical specialty. Clinical experience, however, suggests that such access is not universally available within all health boards. This unnecessary variation, requires some patients to return to their GP to be referred without any additional benefit to either the patient or GP. It is proposed that all boards should clearly define the process and provide a mechanism whereby AHPs can refer direct to other clinical specialties where appropriate.

**Standard K
Process for Onward Referral from Musculoskeletal (MSK) services to Other
Clinical Specialties**

AHP services should have a documented process for onward referral, when and where appropriate.

Allied Health Professional (AHP) Musculoskeletal Pathway Framework

RESPONDENT INFORMATION FORM

Please Note this form **must** be returned with your response to ensure that we handle your response appropriately

1. Name/Organisation

Organisation Name

Title Mr Ms Mrs Miss Dr *Please tick as appropriate*

Surname

Forename

2. Postal Address

Postcode	Phone	Email

3. Permissions - I am responding as...

Individual

/

Group/Organisation

Please tick as appropriate

- (a) Do you agree to your response being made available to the public (in Scottish Government library and/or on the Scottish Government web site)?

Please tick as appropriate Yes No

- (b) Where confidentiality is not requested, we will make your responses available to the public on the following basis

Please tick ONE of the following boxes

Yes, make my response, name and address all available

or

Yes, make my response available, but not my name and address

or

Yes, make my response and name available, but not my address

- (c) The name and address of your organisation **will be** made available to the public (in the Scottish Government library and/or on the Scottish Government web site).

Are you content for your **response** to be made available?

Please tick as appropriate Yes No

- (d) We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

Please tick as appropriate Yes No

Responding to this Consultation Paper

We are inviting written responses to this consultation paper by **16 June 2014**. Please send your response with the completed Respondent Information Form (see "Handling your Response" below) to:

CNOPPPAdmin@scotland.gsi.gov.uk

Or by post to:

Julie Townsend
Scottish Government Health Directorate
Directorate for Chief Nursing Officer, Patients, Public and Health Professions
GE 19, St Andrew's House
Regent Road
Edinburgh
EH1 3DG

If you have any queries please contact Julie Townsend on 0131 244 3739.

This consultation, and all other Scottish Government consultation exercises, can be viewed online on the consultation web pages of the Scottish Government website at <http://www.scotland.gov.uk/consultations>.

The Scottish Government has an email alert system for consultations, <http://register.scotland.gov.uk>. This system allows stakeholder individuals and organisations to register and receive a weekly email containing details of all new consultations (including web links). It complements, but in no way replaces Scottish Government distribution lists, and is designed to allow stakeholders to keep up to date with all Scottish Government consultation activity, and therefore be alerted at the earliest opportunity to those of most interest. We would encourage you to register.

Handling your response

We need to know how you wish your response to be handled and, in particular, whether you are happy for your response to be made public. Please complete and return the Respondent Information Form which forms part of the consultation questionnaire attached as an annex as this will ensure that we treat your response appropriately. If you ask for your response not to be published we will regard it as confidential, and we will treat it accordingly.

All respondents should be aware that the Scottish Government is subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation.

Where respondents have given permission for their response to be made public and after we have checked that they contain no potentially defamatory material, responses will be made available to the public in the Scottish Government Library (see the attached Respondent Information Form). These will be made available to the public in the Scottish Government Library by (date to be confirmed). You can make arrangements to view responses by contacting the Scottish Government Library on 0131 244 4556.

Responses can be copied and sent to you, but a charge may be made for this service.

What happens next?

Following the closing date, all responses will be analysed and considered along with any other available evidence to help us reach a decision on the content of the final AHP Musculoskeletal Pathway Framework.

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