MSK TRIAGE INITIATIVE

All Site Visits Report 2024

280,000+ Patients Managed

18 Hospital Sites

40 Community Locations

HSE NCP T&O NATIONAL CLINICAL PROGRAMME FOR TRAUMA & ORTHOPAEDIC SURGERY RHEUMATOLOGY RCSI ROYAL COLLEGE OF PHYSICIANS OF IRELAND IITOS THE IRISH INSTITUTE OF TRAUMA AND ORTHOPAEDIC SURGERY Clinical Design & Innovation *Person-centred, co-ordinated care*

MAY 2025

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MSK Triage Initiative

All Site Visits Report 2024

MAY 2025

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Acknowledgments

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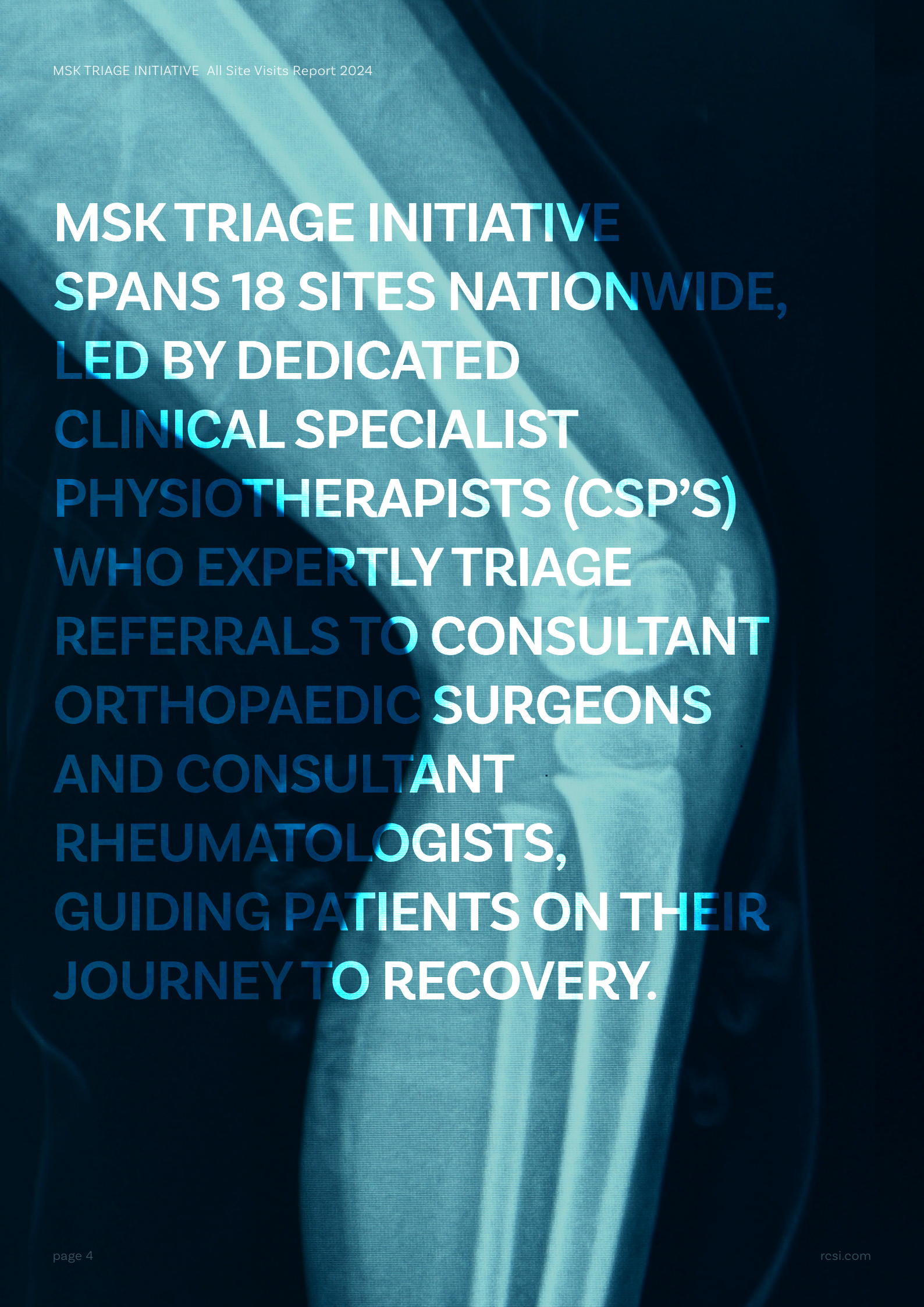
Professor David Kane, Clinical Lead for the National Clinical Programme for Rheumatology

MSK Steering Group Members: **Aisling Brennan**, ***Edel Callanan*** and **Jenny Ashton**.

All the clinical specialist physiotherapists, consultants in orthopaedics and rheumatology, primary and secondary care physiotherapy managers, clerical administrative staff that have supported the initiative and continue to develop the services to improve patients access to timely and appropriate care nationally.



MSK TRIAGE INITIATIVE SPANS 18 SITES NATIONWIDE, LED BY DEDICATED CLINICAL SPECIALIST PHYSIOTHERAPISTS (CSP'S) WHO EXPERTLY TRIAGE REFERRALS TO CONSULTANT ORTHOPAEDIC SURGEONS AND CONSULTANT RHEUMATOLOGISTS, GUIDING PATIENTS ON THEIR JOURNEY TO RECOVERY.

1. Introduction

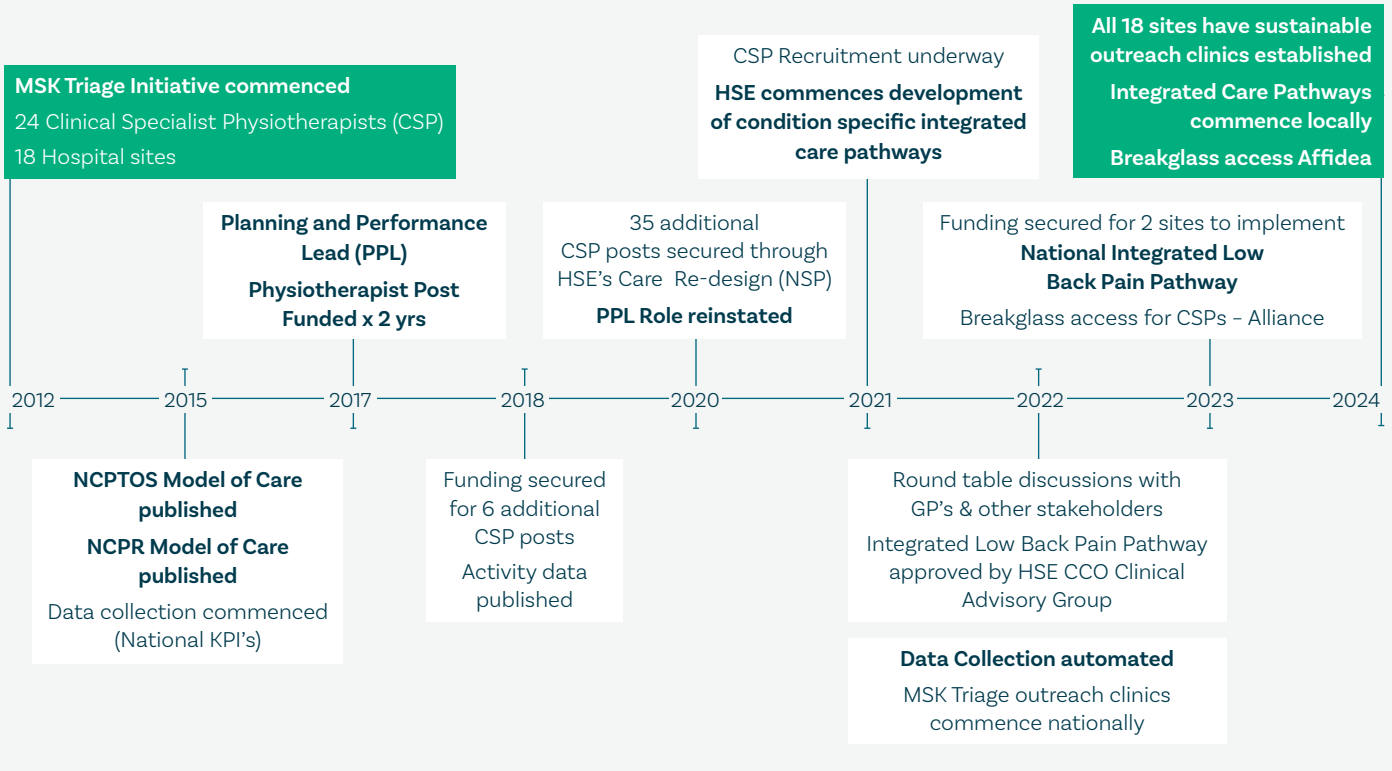
The Physiotherapy led MSK Triage initiative is a joint collaboration between the National Clinical Programme for Trauma and Orthopaedic Surgery and the National Clinical Programme for Rheumatology.

This initiative commenced in 2012, as one solution, to tackle the increasing demand for orthopaedic and rheumatology OPD Services *(Table 1)*, where clinical specialist physiotherapists (CSPs) work under the clinical governance of orthopaedic and/or rheumatology consultants to triage and manage patients that have been referred to orthopaedic and/or rheumatology waiting lists, but are unlikely to require specialist services. The development of this initiative is outlined in *Figure 1*.

Table 01 OPD Waiting Lists (December 2024)

OPD Waiting Lists (end December 2024) *(Source - NTPF)*			
Orthopaedics – Adult	59,764	Rheumatology – Adult	11,665
Orthopaedics - Paediatric	5,849	Rheumatology – Paediatric	5,849
Total Number waiting on OPD WL	**65,613**	**Total number waiting on OPD WL**	**12,382**

Figure 01 Development of the Physiotherapy led MSK Triage Initiative



National Activity Overview

At the end of December 2024, **281,007** patients have been managed through this initiative.

The full breakdown is outlined below in *Table 2*.

Table 02 MSK Triage Activity

MSK Triage Initiative	2012 - Dec 24	Jan-Dec 2024
New Patients	233,952	31,464
Returns	43,728	8,204
New Patient DNAs	47,055	4,878
Discharges	151,207	18,350
Avg. Discharge Rate	64.6%	58.32%
Total Removed to Date	**281,007**	**36,342**

Since **1st July 2024**, all 18 sites have successfully commenced delivering some of their services in **40 community locations**.

This accounts for 18.7% of the initiative's total productivity at present.

Hospital based face-to-face activity is currently at 73.8% with 7.4% of total new patient activity being completed virtually.

Locations for delivery of community-based outreach services include:

- 31 Primary Community Care Centres (PCCC)
- 1 Commercial Building
- 8 Model 2 hospitals

Further details regarding National Activity Data for 2024 is provided in *Appendix 1.*

MSK Triage Initiative Workforce

To date, the HSE has funded **65** whole time equivalent (WTE) CSP posts to deliver this service.

National WTE data returned to the programmes, confirms that:

- The average WTE CSP complement is ~ 55 WTE *(Table 3)*
- This represents a **15% deficit** in staffing levels due to:
  - ~ Non-Backfilled Maternity, Paternity and Parental Leave
  - ~ Non-Backfilled Long-term Sick Leave
  - ~ Inter-Hospital Staff Transfers
  - ~ Recruitment & National Staff Shortages.

Table 03 Physiotherapy led MSK Triage Initiative Workforce 2018–2024

Hospital	2018	2020	2024	Avg. WTE Returns (Jan-Dec '24)
Beaumont	1.5	3	4.5	3.5
Cappagh	2	1	3	2.8
Connolly	1	2.5	3.5	3.3
Galway	3	1.5	4.5	4.8
Kerry	0.5	1.5	2	1.7
Letterkenny	1.5	1	2.5	2
Limerick	3	2	5	4.4
Mater	1.5	1	2.5	2
Mayo	1	1	2	1.3
Naas	0.5	1.5	2	1.6
Navan	1	2	3	3.2
SIVUH	2.5	1.5	4	4.2
Sligo	1.5	2	3.5	3.3
St James	1	2	3	2
St Vincent's	2	2	4	2.5
Tallaght	2	3	5	4.9
Tullamore	1.5	3	4.5	3.7
Waterford	3	3.5	6.5	5.5
Total	**30**	**35**	**65**	**56.8***

**(8.2 post deficit=> 12.6 % deficit/ 87.4% capacity)*

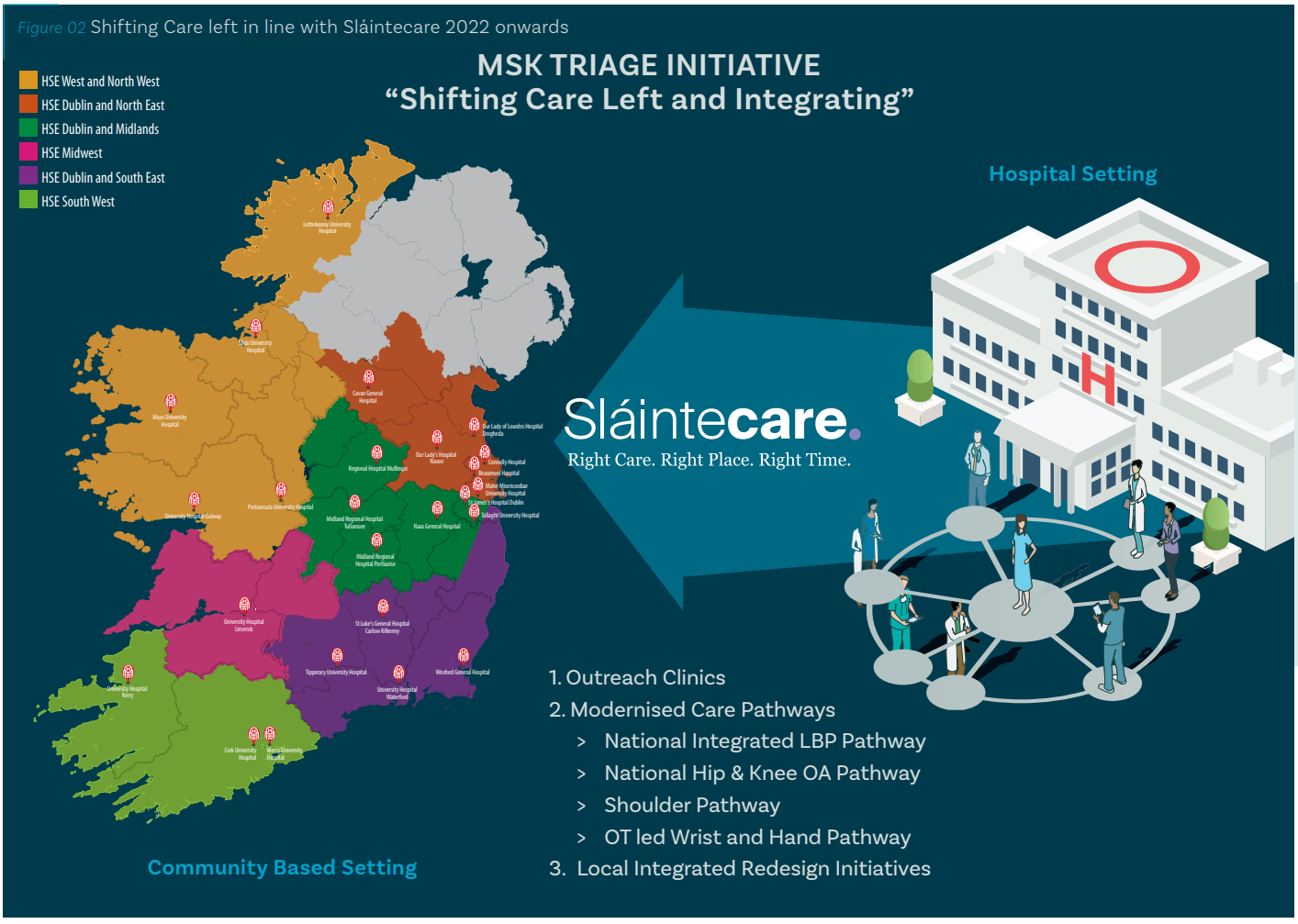
2. Strategic Vision for MSK Triage Initiative

The strategic vision of both programmes, for the physiotherapy led MSK triage initiative, is for CSPs to assess and treat patients presenting with MSK conditions via community-based condition specific integrated care pathways, with consultant-led multidisciplinary team (MDT) interface clinics established to enable patient discussions and progression of management decisions in a timely manner.

Delivery of this vision would optimise the implementation of integrated MSK care for all patients presenting with MSK conditions, including those who may require specialist services at some point in their patient journey.

Since 2022, realising this vision commenced with all participating hospital sites (n=18 hospitals), aligning with Sláintecare principles of shifting care left to deliver MSK triage and treat clinics in community-based locations (n=40) as outlined in *Figure 2*.

Figure 02 Shifting Care left in line with Sláintecare 2022 onwards



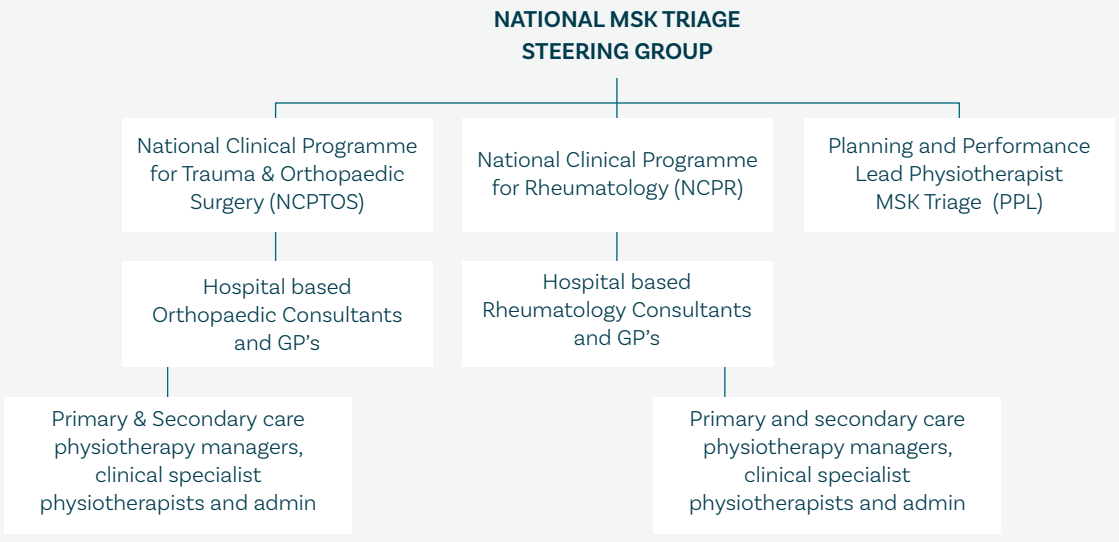
Streamlined integration of acute and community based MSK services is being tested through the implementation of Modernised Care Pathways (MCP) at pilot sites for the most common clinical presentations to orthopaedics and rheumatology i.e. inflammatory and degenerative low back pain, OA hip & knee, shoulder, hand and wrist. Evaluation of these pathways is ongoing and will inform and support participating sites as they look to redesign local MSK services in line with national pathway models.

The longer-term strategic vision would see CSPs working in GP practices (or similar) as first contact practitioners (FCP) managing patients that present with MSK symptoms.

3. Clinical Governance

The clinical governance for this initiative is delivered at both local and national levels as outlined below.

Figure 03 Clinical Governance for the Physiotherapy led MSK Triage Initiative



For the period October 2020 – 2024 respectively, the teams participating in the national initiative, have been supported in all aspects of service delivery by Dr Sarah Casserley-Feeney, Planning and Performance Lead Physiotherapist. Sarah has been the point of contact to support sites with operational queries and to ensure continuation and consistency in the design and delivery of the MSK initiative nationally through regular site visits and meetings. Unfortunately due to a lack of funding from the HSE, Sarah returned to her substantive post in early October 2024

4. Site Visits

During and post the pandemic (2020 – 2023), given the restrictions that were in place for a prolonged period by all hospitals, site visits remained virtual. Feedback from both the clinical specialist physiotherapists and physiotherapy managers highlighted the value of this regular engagement and the need to move back to in-person visits to discuss local issues.

In 2024, it was agreed that reinstating in person site visits by the Planning and Performance Lead Physiotherapist was a key priority.

These visits were scheduled between February and August, with follow up engagements by the PPL via email, phone or MS Teams to all sites when required *(Site Visit Schedule - Appendix 3)*.

The purpose of the site visits was to discuss the following:

- Performance & progress of the MSK Triage Initiative at site and national level
- Site updates regarding local initiatives that complemented the delivery of MSK Triage Services
- Support future planning for local development of MSK Triage services
- Support sites with any other operational queries

Figure 04 Process utilised when planning site visits

Site visits were attended by MSK physiotherapy managers and the majority of CSPs, with representation from other stakeholders including patients, community physiotherapy managers, GPs, scheduled care managers and clerical administrative staff at many of the meetings.. Thirty four percent of site visits had consultants in attendance.

These site visits have provided an **"As Is Picture"** for the initiative, particularly with regard to the establishment of community-based MSK Triage clinics and the planning and/or implementation of local integrated MSK condition specific care pathways.

KEY FINDINGS FROM SITE VISITS

- **Potential Impact of MSK Triage Initiative on OPD Waiting Lists**
- **Referral Triage Processes & OPD Waiting List Data Management Systems**
- **MSK Triage Initiative Operational Processes**
- **Weekly CSP Schedules**
- **Activity Monitoring & Data Collection Processes**

4.1 Potential Impact of MSK Triage Initiative on OPD Waiting Lists

A key finding from these site visits, suggests that **63% of orthopaedic referrals are currently triaged/deemed suitable for MSK Triage to manage, with data from 12 sites suggesting that 25% of rheumatology referrals are currently triaged/deemed suitable for MSK Triage Services**. This finding is based on the analysis of data from 13 sites, who undertook a manual review of their OPD waiting lists, with the five remaining sites unable to extract this information.

This finding demonstrates the significant potential impact that this initiative can have on National OPD orthopaedic and rheumatology waiting lists. However, this finding needs to be interpreted with care as all data was manually extracted by clinicians. This represents just one example of the inefficient use of clinical time, and highlights the need for robust IT solutions to improve the management and analysis of OPD waiting list data, to ensure that accurate data is readily available to inform future service design and delivery.

4.2 Referral Triage Processes & OPD Waiting List Data Management Systems

At each site, CSPs continue to work closely with nominated orthopaedic and rheumatology consultants, as clinical governance for the patients remains with the named consultant that the referral has been logged under on the patient management system.

On fourteen (78%) of the eighteen sites, the IT patient management system in use is iPMS - "Integrated Patient Management System".

Table 04 IT systems in use across participating sites

MSK Triage Initiative	No. of Sites	Sites
PAS – Patient Administration System	3	St James's Hospital
		Tallaght University Hospital (TUH)/ Naas General Hospital
		St Vincent's University Hospital
HIS - Hospital Information system	1	Beaumont Hospital
Patient Centre	3	Mater Misericordiae University Hospital (MMUH)

Four sites have access to Electronic Health Records (EHR)

- St James's Hospital (Cerner);
- Merlin Park University Hospital (Evolve),
- TUH and Naas (Cellma), with varying functionality for remote use for each site.

No site has access to an Integrated Electronic Healthcare Record (i.e. shared access to patient records in community and acute services). In 15/18 sites (83%), the MSK Triage list sits under the consultant's name in orthopaedics or rheumatology. The other 3 sites (Galway/ TUH/Letterkenny University Hospital (LUH)) have varying processes in this regard, which are currently under review.

In 13/18 sites (72%), the MSK Triage lists were not set up in a manner that allows automated reporting of the impact that this service is having on local OPD waiting lists.

Reportable data regarding patient address (n = 2 sites) or presenting complaint (n = 4 sites), was very limited across all sites visited. Whilst some of this data could be extracted manually, there is **no dedicated clerical administration in local Central Reporting Offices (CROs) at any site to support these activities**, which tend to become clerical administrative tasks for CSPs, should they wish to explore their waiting lists. This presents a significant barrier to facilitation of local/regional data driven decisions to inform local, regional and national service delivery and planning.

4.3 MSK Triage Initiative Operational Processes

During these site visits it was noted that there is a growing trend for referrals to be triaged by CSPs on orthopaedic waiting lists with 33% (n=6) hospitals now agreeing to some form of CSP triage of initial referrals. Alongside this, one hospital reports that CSPs work chronologically off the routine longest-waiters lists, with no active pre-screening or triage of routine orthopaedic referrals.

A pilot to explore **inter-rater concordance** between CSPs decisions with those of orthopaedic consultants on new referrals to orthopaedic waiting lists in University Hospital Limerick, confirmed 100% inter-rate concordance for red-flag presentations, and 89% inter-rater concordance for determining whether a patient should be seen in MSK Triage or orthopaedics (*Appendix 4*). These results confirm the feasibility of safely delegating this task to CSPs and provides an audit tool to guide and monitor clinicians who wish to progress with this process.

At present, given the complex range of possible presentations to rheumatology, consultants continue to complete initial triage of all rheumatology referrals at the participating sites.

Table 05 Referral Triage Processes

Referral Triage by	Orthopaedic	Rheumatology
No pre-Triage of Referrals	1 (6%)	0 (0%)
CSP only	2 (11%)	0 (0%)
CSP/Consultant	4 (22%)	0 (0%)
Consultant	11 (60%)	17 (100%)

4.4 Weekly CSP Work Schedule

Since 2012, the proposed weekly CSP work schedules of "**5:3:2**" has been recommended by the MSK Steering Group.

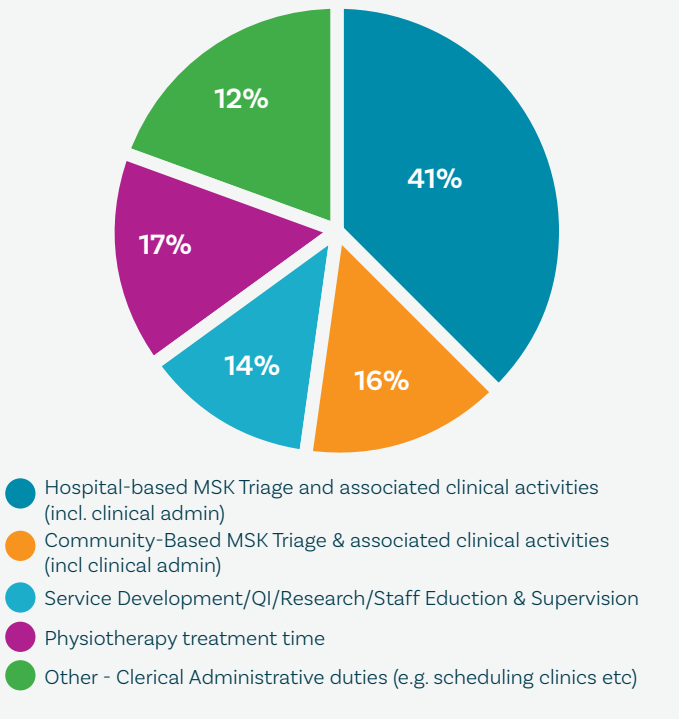
This includes:

- 5 x MSK Triage Clinics
- 3 Physiotherapy Treatment Clinics
- 2 x Clinical Admin/Research/Service Development

During the site visits, it was evident that CSP weekly schedules are changing in response to the increasing volume and complexity of patients deemed suitable for the MSK Triage Initiative, alongside a gradual shift in service delivery, as skillsets and CSP scope increases (e.g. CSP Early Arthritis Clinics & Injection Clinics).

Appendix 6 and *Figure 7* present data, submitted from 13 sites, to reflect the breakdown of weekly activity, and suggests that **c 12% of CSP time is being spent on Clerical Administration duties**.

Figure 07 Total weekly sessions/CSP



The findings support the need for a review of current weekly CSP schedules, associated targets and KPI's that align more closely with an evolving service delivery model, whilst also acknowledging system deficits that impact on potential productivity.

4.5 Activity Monitoring & Data Collection Processes

Physiotherapy led MSK triage activity is monitored using 4 Key Performance Indicators (KPIs) which were agreed when the MSK Triage Initiative commenced.

Data is submitted by each site on a monthly basis to a national MSK Data SharePoint site which is hosted by RCSI.

The four Key Performance Indicators's are outlined below:

Key Performance Indicators (KPI's)	Annual Target per WTE	Monthly Target per WTE
01. Number of new MSK orthopaedic and rheumatology attendances seen by MSK physiotherapist (Target for community-based setting)	n=900 (n=636)	n=75; (n=53)
Total Number of Patients Booked (Target for community-based setting)	**n=1008; (n=706)**	**n=84; (n=59)**
02. Percentage of new patients seen vs return patients	>90% New patients	>90% New patients
03. Percentage of new referrals triaged as appropriate for MSK Triage Service, that are seen by an MSK physiotherapist within 3 months of receipt of referral at hospital centre.	>70% seen within 3/12	>70% seen within 3/12
04. Percentage DNA rate for MSK Triage new patient appointments	< 12%	< 12%

Since 2021, the MSK Data Return Sheet has been reviewed and updated annually to reflect changing service needs within the MSK Triage Initiative, driven by external influences (e.g. pandemic, cyber-attack) and by the implementation of health policies such as Sláintecare.

This is reflected through the inclusion of telehealth activity, updated patient-outcome data, community-based face to face activity. These changes have been co-designed with CSP representatives, to ensure that the maximum of meaningful data can be gathered with the minimum burden on clinicians who submit the data on a monthly basis.

KPI data from January-December 2024 is presented in *Figure 5* and demonstrates that sites are not reaching national targets associated with KPIs. It is likely that this reflects a gap between current service delivery model, and the service model at the time when the existing KPIs were developed. This reinforces the recommendation in **Section 4.4** that changes in service delivery should be accompanied by review of existing KPIs and associated targets.

A six-year review (2018 to 2023) of data trends for the primary 4 KPIs is currently underway, to explore changes in trends as the MSK Triage initiative evolves. Findings from this review may also help to inform future KPI and associated targets for the MSK Triage Initiative.

Figure 04 Process utilised when planning site visits

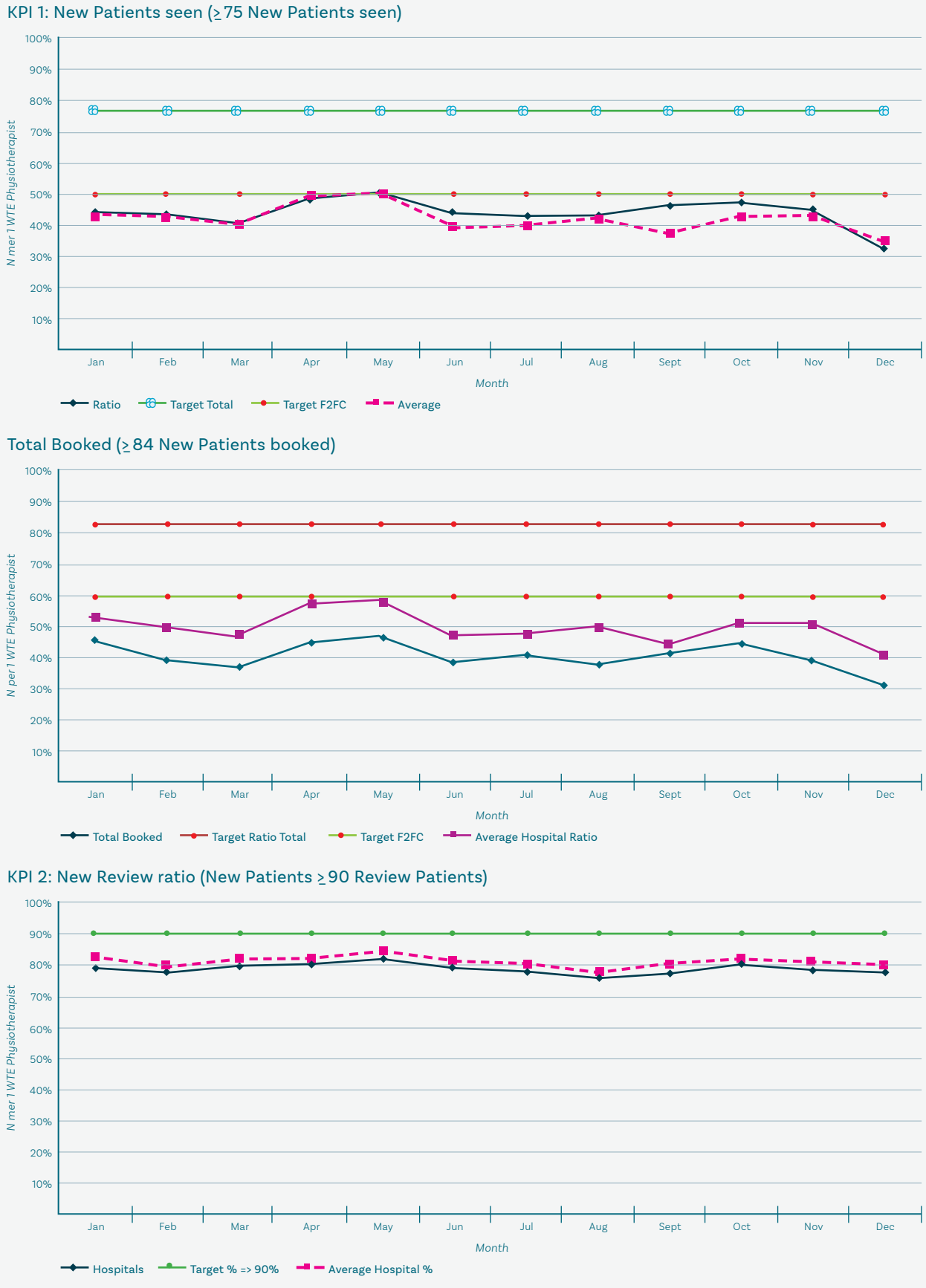
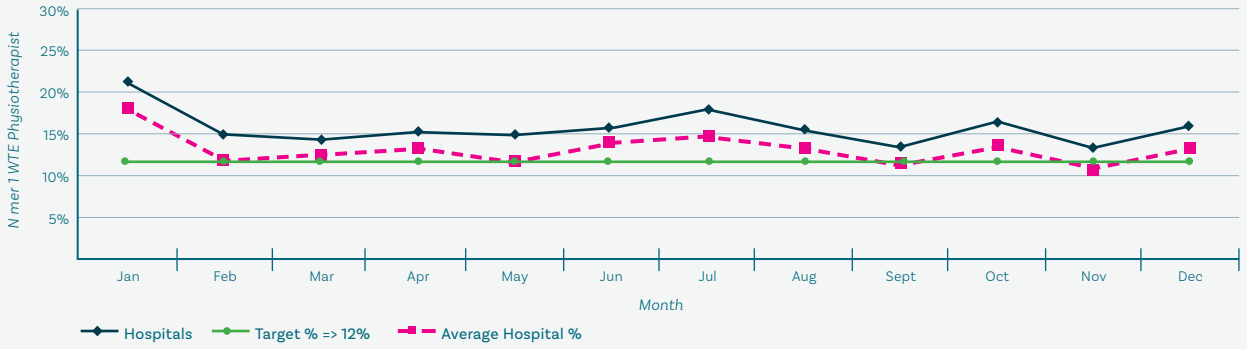


Figure 04 Process utilised when planning site visits

KPI 3: New Patients seen (≥ 3 months

KPI 4: DNA rate (≥ 12%)



5. Challenges & Opportunities / Potential Solutions

5.1 Community-based accommodation

The standard of community-based accommodation is excellent on most sites, with suitable clinic rooms and waiting areas, excellent parking facilities and many sites with access to radiology, GP and other HSCP services on site.

However, access to booking these community-based clinics has been a significant challenge for the national roll-out of community-based triage clinics, with most sites only able to book clinic rooms on a 4-6 weekly basis. This presents a challenge to the sustainable implementation of the community-based component of this initiative. The provision of 6 monthly booking schedules would support greater medium to long-term planning for future delivery of the initiative.

5.2 Information Technology/Digital Challenges

Remote access to laboratory and radiology reports (NIMIS)/Patient Management Systems (e.g. iPMS) and online Transcription (e.g. T-Pro/Winscribe) is available to all sites via work laptops or mobile phones.

However, remote access is dependent upon broadband and Wi-Fi signals in the community-based settings, which present a challenge in many sites. Use of dongles is required at times where Wi-Fi is unreliable to ensure that relevant patient investigations can be viewed.

A further challenge arises for non-HSE hospital staff (e.g. Section 38/39 organisations) who are delivering community-based clinics in HSE locations, as these staff do not currently have any permission to access HSE Wi-Fi Solutions in this regard have included:

- Use of a local integrated SLA to provide access for non-HSE hospital staff to HSE laptop or desktop in HSE locations;
- Use of Wi-Fi Dongles/mobile phone hotspots for these staff to access their work laptops.

5.3 Chart Movement & Documentation

The lack of an integrated electronic healthcare record and the HSE's over-dependence on paper-based referrals and patient charts, presents a challenge at most sites, which has required the implementation of local chart management and transport processes, to ensure that patient referrals and clinical charts are available to clinicians at community-based clinics.

Various short-term solutions ('work-arounds') have been developed at all sites.

These include:

- Scanning patient referrals and patient notes, which are then emailed to clinicians for remote access.
- Taxi transfer of the physical charts.
- In some sites, the CSPs themselves transport the charts in adherence to HSE guidance regarding transport and storage of patient charts.

Aside from potential risks associated with these work-arounds, it is clear that these are inefficient in terms of clerical and clinical workloads and system cost, with associated impact on clinical productivity.

An efficient solution will be the implementation of an Integrated Electronic Health Record, with Unique Patient Identifier which will ensure shared access to complete relevant patient information regardless of clinic location.

5.4 Clerical Administration Resources

Clerical Administration remains the most consistently cited challenge to the productive delivery of the Physiotherapy led MSK Triage Initiative, with clinical specialist physiotherapists regularly undertaking clerical administrative duties to ensure that clinics can run.

In 2022, it was estimated that the weekly time taken to deliver these clerical tasks was 4.6 hours per CSP, with a potential loss of 7 new patients per CSP per week **(294 new patient slots per CSP per annum/19,110 to the service pa**).

Evolving digital solutions for transcription and typing of clinical letters have provided some support in this regard. However clerical administration tasks including clinic appointment scheduling, management of DNAs/CNAs and the administrative tasks involved with chart management and transport are still undertaken by CSPs on many sites due to lack of clerical administration resources, with ongoing impact on clinical capacity/time.

5.5 Potential costs associated with hybrid service delivery e.g. Room hire; travel between hospital and community-based locations

It is well accepted that staff working between hospital and community-based location epitomises the concept of integrated care, and is critical to the development of integrated staff relationships, upon which sustainable integrated service delivery is based. This ensures that patients can enjoy the access to services at the lowest level of complexity, yet be assured of seamless transfer to specialist services in a timely manner when required.

It must be acknowledged that delivery of this service model incurs travel time for staff, with an associated impact on traditional measures of productivity.

As part of the site visits, data regarding the distance between hospital and community-based locations were mapped with a view to estimating the impact of travel time, and found that the **potential average distance between hospital and community-based sites was 17km (range < 5-75km), with average travel time of 24 minutes (range: 10 - 75 minutes)** (*Appendix 6*).

As expected, variance in the ranges was due to differences in urban and rural configurations with the latter having longer distance and travel times.

(*Actual average times and distances provided are the maximum possible, as many CSPs provide service at community-based locations, closer to their home-base, in which case this becomes maximum travel time allowable).

No site reported any ongoing rental or lease cost for room hire in community-based locations.

6. Conclusion & Recommendations

Feedback and learnings from the site visits provide an "As Is" overview of the MSK Triage Initiative, which suggests that this initiative continues to be a positive healthcare exemplar, as it progresses in shifting care left in line with current Sláintecare policy, towards the delivery of integrated care for patients with MSK conditions in Ireland.

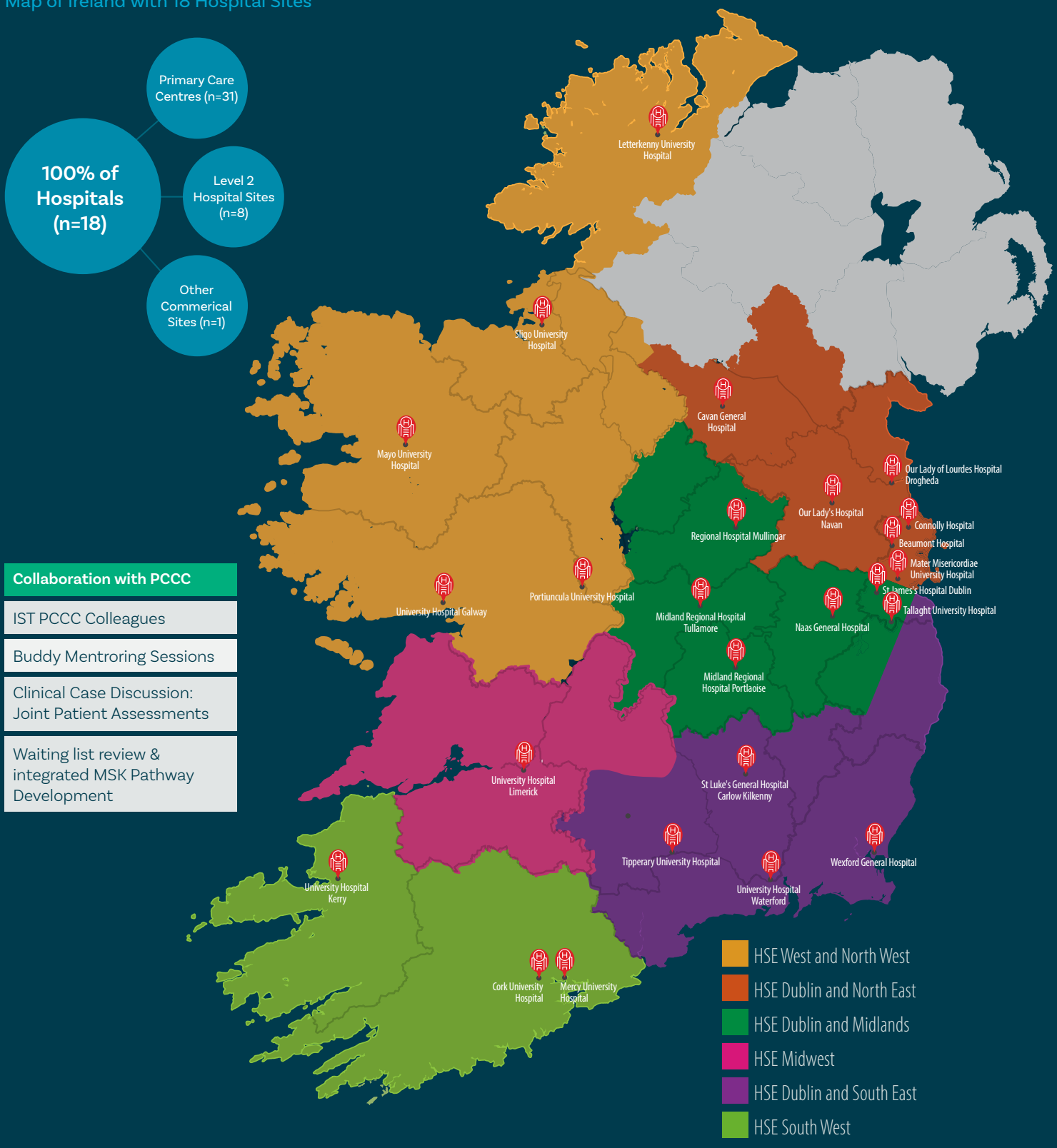
However sustainable success and optimal productivity of this initiative requires greater consideration in the context of the complex socio-technical system of the HSE, including the reconfiguration into Health Regions. This is critical to ensuring that clinicians are adequately supported and enabled to deliver clinical services through the appropriate provision of ancillary support services such as clerical administration and responsive patient information and data collection systems.

Changes in service delivery should be accompanied by review of existing KPIs and associated targets to reflect the evolution of the National MSK Triage Initiative. As part of this, tools to monitor and evaluate service performance must be reviewed to reflect the evolving service model and must include a greater focus on patient centred qualitative measures.

Finally, staff feedback regarding the value of site visits was resoundingly positive, with a number of sites acknowledging the positive impact of the site visit as a mechanism for reinforcing national policy in a manner that is relevant and tangible at site level, and also the positive impact of the site visit in progressing local MSK service development projects.

APPENDICES

Appendix 1:
Map of Ireland with 18 Hospital Sites



Appendix 2:
MSK Data: January-December 2024

National MSK Triage Activity	2012 - Dec 24	Jan-Dec 2024
New Patients	233,952	31,464
Returns	43,728	8,204
New Patient DNAs	47,055	4,878
Discharges	151,207	18,350
Avg. Discharge Rate	64.6%	58.32%
Total Removed to Date	**281,007**	**36,342**
Breakdown of new patient activity by specialty 2024	Orthopaedic - 87% Rheumatology - 13%	
Breakdown of new patient activity by location/type 2024	Hospital-based Face- to-Face -73.8% Community-based Face-to-Face -18.7% Virtual = 7.4%	

Appendix 3:
Site Visit Schedule

Hospital Site & Community-based Clinic	Date
Our Lady's Hospital - Navan	26.02.2024
Beaumont Hospital	26.02.2024
Naas General Hospital	07.03.2024
Mayo University Hospital	08.03.2024
St Vincent's University Hospital-> Clonskeagh	11.03.2024
Donegal -> Letterkenny University Hospital	19.03.2024
Athlone->Midlands Regional Hospital Tullamore	09.04.2024
National Orthopaedic Hospital Cappagh	11.04.2024
Mater Misericordiae University Hospital	12.04.2024
Tuam -> Galway	16.04.2024
Tallaght University Hospital	22.04.2024
Inchicore-> St James Hospital	22.04.2024
University Hospital Waterford	23.04.2024
South Infirmary Victoria University Hospital	30.04.2024
F/up - Beaumont Hospital (REVIEW)	20.05.2024
University Hospital Limerick/Croom	21.05.2024
Sligo University Hospital/OLHM	23.05.2024
Connolly Hospital - Blanchardstown	29.05.2024
University Hospital Kerry (UHK)*	21.06.2024
F/up - UHK (REVIEW - NCPTOS)	23.08.2024

Appendix 4:

Inter-rater Concordance for MSK Triage between an Orthopaedic Consultant & a Clinical Specialist Physiotherapist.

"The inter-rater agreement for MSK Triage between an Orthopaedic Consultant and a Clinical Specialist Physiotherapist (CSP) – a University Hospital Limerick (UHLG) Concordance Study"

Scott Murphy, Julie Sugrue, Mark Kingston, Olivia McKenna, Catriona O'Dwyer, Paula Wallace, Dr. Seán McKenna, Mr Finbarr Condon, Dr Sarah Casserley-Feeney

INTRODUCTION

Referrals to outpatient (OPD) Orthopaedics at UHLG have traditionally been triaged by Consultants.

As part of service review, the Orthopaedic team, agreed to explore the delegation of this task to other senior decision makers. The scope of practice of CSP's working in extended scope roles such as MSK Triage. includes screening for red flags, diagnosis of MSK problems, and onward referral to appropriate services *(Moffatt et al., 2018)*.

Evidence shows comparable diagnostic accuracy between physiotherapists and Orthopaedic Consultants regarding clinical diagnosis *(Moore et al., 2005), with 85% agreement regarding management plans (Napier et al., 2013).*

The current study sought to explore the concordane between CSPs and Orthopaedic consultants for the triage of referrals, with a view to delegation of task in ULHG.

METHODOLOGY

Observational, single-centre prospective study, where the same referrals were triaged independently by both raters, who were blinded to each other's triage decision(s).

Concordance rate was measured as the number of referrals with same decision by both raters divided by the total number of referrals

Quantitative variables were analysed using descriptive statistics, and presented in Tablular form using MS Excel (2013) .

RESULTS

A total of 64 Referrals were reviewed independently by both raters, who were blinded to each other's triage decision(s).

Inter-rater concordance results were:

i. Red Flag: 100% (n=64)

ii. Destination: 89% (n=57)
Reasons for discordance included lack of imaging, impact on ADLs, lack of subjective history details.

iii. Priority 77% (n= referrals)
Reasons for discordance tended to be clinician specific with CSPs placing greater emphasis on Quality of Life, with Orthopaedic consultant tending to place greater emphasis on surgical indication.

Time: The average time required to complete paper triage for was 63 minutes per week, this was inclusive of discussion of red flag referrals with a consultant .

Table 01 Inter-rater Concordance.

Inter-rater Concordance	Yes	No	N/A	Ttl.
Red Flag % (n)	64, 100%	0, 0%	0, 0%	**64**
Destination % (n)	57, 89%	7, 11%	0, 0%	**64**
Priority % (n)	49, 77%	11, 17%	4, 6%	**64**

Table 02 Destination Results for each rater.

Inter-rater Concordance	To Ortho OPWL		To MSK OPWL	
Ortho Consultant Triage n=64	26	40.6%	38	59.4%
CSPs n=64	21	32.8%	43	67.2%

Table 03 Destination Results for each rater.

		To Ortho OPWL	To MSK OPWL
Ortho n=64	Red Flag	1	0
	Urgent	19	6
	Routine	3	31
	Not Indicated	3	1
CSP n=64	Red Flag	1	0
	Urgent	14	16
	Routine	6	27
	Not Indicated	0	0

Table 04 Time for Referral Triage

Number of Referrals Triaged	Time Taken (min)
12	40
15	90
37	60
Average	63

KEY FINDINGS

>> CSP-led triage presents a safe and effective means to manage orthopaedic referrals, which may increase surgical time for orthopaedic consultants.

>> This study provides a process by which delegation of this task can be safety planned to allow upscaling of this task in other sites and other clinical specialties (e.g. Rheumatology).

>> Further work is necessary to explore reasons for discordance regarding prioritisation, with authors recommending that prioritisation could be completed by clinicians within the service to which the referrals are triaged.

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Appendix 5:
Weekly Schedule Data for CSP's

CSP Activities	Total weekly sessions/CSP	Average weekly sessions/CSP	Weekly average hours/CSP
MSK Triage Hospital-Based incl. Clinical Admin	43	3.3	11.6
MSK Triage Community-Based incl. Clinical Admin	21	1.6	5.7
Patient Clinical Discussion Time	3.5	0.3	0.9
Virtual NP	0.5	0.1	0.1
Virtual Patient Reviews	4.3	0.5	1.2
Injection Clinic	2.3	0.2	0.6
Physiotherapy treatment time	21.5	1.7	5.8
Service Development/QI/Research	10.3	0.8	2.8
Staff Education/Supervision	8	0.6	2.2
Other- Clerical Administrative duties (e.g. scheduling clinics etc)	15.4	1.2	4.1

Appendix 6:
Travel Time & Distance Data

CSP Activities	No of Sites	Total KM	Average km	Total Min	Average mins
Community-based Site 1: Travel Impact (n=18)	18	301.0	16.7	425	23.6
Community-based Site 2: (n=17) Travel Impact	17	354.0	20.8	440	25.9
Community-based site 3 (n=11). Travel Impact	11	376	34.2	425	38.6
Community-based site 4 (n=5). Travel Impact	5	182	36.4	180	36
Community-based site 5 (n=1). Travel Impact	1	59	59	60	60
Totals Average (Not proportioned)			**33.4**		**36.82**
Distance Range: <5 to 75km					
Travel Time Range: 10 to 75mins					

THE NATIONAL MUSCULOSKELETAL TRIAGE INITIATIVE
"A DECADE OF SUCCESS 2012 - 2022'

200,000+ Patients Managed via MSK Triage Initiative

65 Clinical Specialist Physiotherapists

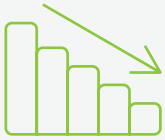
98% Patient Satisfaction

"My experience was excellent"

"I'm satisfied seeing an MSK Physiotherapist instead of a Consultant"

67% Average Discharge Rate

Data Submission Portal Online at all Sites



Est. 60% Reduction in Waiting List Growth*
*(*among appropriate referrals*

12 MSK OUTREACH CLINICS COMMENCED

2012

- Concept for National MSK Initiative Approved.
- 24 Clinical Specialist Physiotherapists (CSPs) appointed.
- MSK Triage Service Launched at 18 Sites Nationwide.

2015

- Significant Review of Data Collection Systems.
- Collection of first Patient Satisfaction Data.
- Compilation of Data for Publication.
- Business Case for Planning and Performance Lead (PPL) Physiotherapist Approved.

2018

- PPL Physiotherapist in post.
- Expansion of Service with 6 new CSPs.
- Patient Satisfaction Survey II Completed.
- First Mass-Data Review Published.
- Business Case for MSK Interface Clinics

2020

- Establishment of MSK Telehealth Services in response to COVID-19 Pandemic.
- Expansion of the CSP workforce with an additional 35 WTEs to:
  - ~ Optimise hospital-based MSK Services.
  - ~ Develop community-based MSK clinics.

2022

- Strengthened MSK Data Monitoring Systems.
- Commencement of MSK services in community-based
- MSK Outreach/Interface clinics.
  - ~ >1,800 patients managed in first 6 months.
- Design of Integrated Condition Specific MSK pathways

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