



Community Appointment Days Evidence Review & Evaluation

Interim report
August 2024

Table of contents

Interim report	1
August 2024.....	1
Acknowledgements	2
Executive summary of findings	3
Background	6
Musculoskeletal care in the UK.....	6
Community Appointment Days in Sussex.....	6
Purpose of this report	8
What is included	8
What is excluded.....	9
How to read this report.....	9
Methods	10
CAD patient survey	10
CAD patient interviews.....	10
CAD staff survey	11
Activity and waiting list quantitative data extracts.....	11
Findings	12
CAD patient survey	12
CAD patient interviews.....	16
CAD staff survey	20
.....	22
Demographic, activity and waiting list analysis.....	27
Discussion.....	38
Interpretation of findings against KEQs	38
Limitations	42
Conclusions and recommendations.....	43
Appendix A: Patient survey questions	45
Appendix B: Staff survey questions	46

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Executive summary of findings

This report synthesises the findings from an analysis of existing evaluative data sources with regard to the Community Appointment Day (CAD) initiative, focusing on its impact on patient's ability to self-manage their condition in their own personal context, NHS service utilisation, patient and staff experience, adoption rates and equity. By analysing and triangulating these data sources, the report aims to provide evidence-based conclusions about the CAD initiative's overall effectiveness, highlight areas for improvement, and identify further research needs.

Support for self-management

The primary goal of the CAD initiative is to deliver a different model of care which aims to support attendees in self-managing their conditions and identify necessary next steps for further treatment. Before CAD, typical care involved a single physiotherapist-led assessment and treatment, where appropriate onward referral or discharge. The CAD initiative, which facilitated discharge to self-management for more than half of the attendees, suggests a significant impact on long-term service utilisation. Instead of multiple appointments, patients usually need just one CAD appointment, potentially reducing demand on downstream clinics.

The high discharge rate to self-management, coupled with qualitative feedback indicating patient confidence in new skills and information, suggests a reduced need for follow-up, at least in the short term. A comparison of PIFU as an outcome at first appointment for new patients attending the CAD versus those in other Sussex MSK Partnership services shows a much higher rate for CAD patients (>50%) compared with just 12%. The PIFU return rate for other services is around 10% and for CAD patients is higher at 23%; however given that the PIFU outcome is four times higher in CAD patients than for patients in other services, this suggests that the CAD does have a positive affect on the longer term self-management. However, it should be noted that the broader evidence base for PIFU's effectiveness in promoting self management is limited. A longitudinal approach linking CAD attendees' data across various healthcare records is recommended to comprehensively assess the impact on service utilisation.

Patient Experience

Patient feedback through surveys and interviews indicates an overwhelmingly positive experience with CAD. The initiative's goal to support and involve patients in their care has been well-received, with patients feeling listened to and that their concerns were addressed. Positive sentiments were particularly strong regarding the face-to-face expert advice and personalised care received during CAD, despite operational concerns like waiting times and navigation issues.

Overall, the evidence suggests that patients engaged well with the CAD format, enjoyed the experience, and found personal benefits. The key goal of enabling active participation in care has been met from the patients' perspective.

Staff Experience

Staff from diverse professional backgrounds reported enjoying the CAD events, finding them beneficial for both patients and their professional development. Positive sentiments included the opportunity to spend quality time with patients, understanding their needs, and providing tailored advice and treatment. The collaborative environment fostered a sense of collegiality and shared purpose among staff. There was some negative feedback, primarily focused on operational issues such as workflow, capacity, and IT challenges. Staff suggested that better

preparation and operational adjustments could improve future CAD events. The overall staff experience was positive, reinforcing the value of the CAD approach in fostering professional and patient engagement.

Adoption and Attendance

High conversion rates from invitation to attendance suggest good adoption of CAD across different areas. However, variations in attendance by age group indicate potential barriers for working-age adults. Feedback indicated that more advance information and better preparation might improve attendance rates, particularly for those with competing priorities.

Further analysis of demographic factors and follow-up with non-attendees could provide additional insights into barriers and preferences, potentially enhancing future CAD events' accessibility and appeal.

Exploration of Broader Health Issues

Evidence from patient and staff feedback suggests that CAD attendees could explore broader issues affecting their MSK conditions. However, the quantitative data on the broader health and wellbeing services offered at CAD events is limited. Low attendance at the community hub could indicate a need for operational improvements to enhance patient flow and engagement with these services. Consideration should also be given to this data set being of relatively poor quality, which could be addressed in future iterations.

Impact on Equity

Analysis by age, gender, and deprivation suggests that the CAD initiative does not perpetuate inequalities, evidenced by a potentially appropriate differential in follow-up care by deprivation level. However, higher DNA and cancellation rates among working-age adults indicate areas for improvement in accessibility for this age group.

Impact on waiting times

The CAD initiative was not primarily designed to reduce waiting lists, but this has emerged as a potential side effect due to the significant number of patients discharged to self-management. Statistical process control analysis of numbers of people waiting for MSK services reveals a broadly stable trend for Sussex MSK Partnership from January to May 2024. In contrast, the overall England trend shows a continuous rise in waiting list volume throughout 2023 and into 2024. Despite general patterns of increasing demand, Sussex MSK Partnership has significantly reduced the number of patients waiting over 18 weeks, outperforming the national trend. Although no direct causal link between the CAD initiative and waiting list reductions can be confirmed, correlations in timing and qualitative findings suggest a positive impact.

Further analysis would be needed for clearer evidence of CAD's long-term effects on waiting times. However, if a causal relationship is present, these patterns, coupled with low rates of PIFU suggest that the impact on MSK waiting times for Sussex MSK Partnership could be sustained in the long term if the CAD initiative continues.

Limitations and Recommendations

This interim report is based on limited data from six CAD events and lacks a comparator group. Further analysis with longitudinal data and independent qualitative data collection is recommended to strengthen the evaluation. Key recommendations include:

1. Commission independent qualitative data collection to supplement existing staff and patient experience data and follow-up with non-attendees.
2. Link CAD attendee data to primary and secondary care records to assess pre- and post-CAD service utilisation.
3. Refine the current data available on PIFU; research the utilisation of PIFU by CAD attendees, stratified by key demographics and analyse follow-up initiation reasons.
4. Maintain a record of review and learning activities related to the CAD initiative and implement operational improvements based on these insights.

Overall, based on the available evidence, the CAD initiative has met its stated goals and shown positive impacts on patient self-management and staff engagement. There are opportunities for further improvement in operational execution and data collection to support more comprehensive evaluations.

Background

Musculoskeletal care in the UK

Musculoskeletal (MSK) conditions are among the fastest growing reasons for seeking healthcare support in the UK. MSK conditions, which include a range of disorders affecting bones, muscles, and joints, are becoming increasingly prevalent due to aging populations and rising levels of physical inactivity.

Research indicates that MSK conditions are one of the leading causes of disability in the UK, significantly impacting individuals' quality of life and placing a considerable burden on healthcare services and the wider economy^{1,2}. In Great Britain, work-related MSK conditions account for a significant proportion of work-related sick days, responsible for approximately 6.6 million lost working days in 2022/23, which represents about 21% of all work-related illness days³. This places MSK disorders as the second highest cause of work-related ill health, following stress, depression, or anxiety.

The demand for MSK care is evident in the significant MSK waiting list; at the time of writing 840,000 people were waiting for their first definitive, consultant led, treatment under the 'Trauma and Orthopaedics' specialty⁴. In community services, the national waiting list for adult MSK services is estimated at 321,000 people⁵. This demand is also evident in primary care. Studies indicate that approximately 21%⁶ of all general practice consultations are related to MSK issues, although changes in practice with the advent of first contact practitioners in primary care may have led to a change in this figure. Approximately 30% of people referred to specialist care for MSK conditions end up without a clear outcome and are often sent back to GPs, leading to an ongoing cycle of demand.

The NHS Long Term Plan emphasised the need for enhanced support and treatment options for people with MSK conditions to manage their symptoms and maintain quality of life. The need for optimised referral pathways and more effective integration between community based and specialist care has never been more needed.

Community Appointment Days in Sussex

Community appointment days (CADs) in MSK services is an initiative in Sussex, which has been designed to offer a comprehensive range of MSK services, tailored to the needs of the local population, under one roof, in a community setting, generally a local leisure centre. The approach was designed with a number of objectives in mind:

- Provide same-day access to holistic services including where appropriate, assessment, advice and guidance, rehabilitation, health promotion and VCSE support

¹ NHS England. (2017). *Improving musculoskeletal health: A toolkit for Commissioners*. Accessed: <https://www.england.nhs.uk/wp-content/uploads/2017/02/musculoskeletal-health.pdf>

² Versus Arthritis. (2019). *State of Musculoskeletal Health 2019*. Accessed: <https://www.versusarthritis.org/media/14594/state-of-musculoskeletal-health-2019.pdf>

³ Health and Safety Executive (2023) Work-related musculoskeletal disorders statistics in Great Britain. Accessed: <https://www.hse.gov.uk/statistics/assets/docs/msd.pdf>

⁴ NHS England (2024). Referral to Treatment (RTT) Waiting Times. Accessed: <https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/>

⁵ NHSEngland (2024). Community Health Services Waiting Lists. Accessed: <https://www.england.nhs.uk/statistics/statistical-work-areas/community-health-services-waiting-lists/>

⁶ Jordan, K. P., Kadam, U. T., Hayward, R., Porcheret, M., Young, C., & Croft, P. (2010). Annual consultation prevalence of regional musculoskeletal problems in primary care: an observational study. *BMC Musculoskeletal Disorders*, 11, 144.

- Provide a non-medicalised environment that encourages people to engage with and manage their own conditions and general health and wellbeing wherever possible
- Embed personalised care into all aspects of the CAD intervention, ensuring MSK advice and treatment is supported by an in depth understanding of patient priorities and wishes
- Provide the opportunity for CAD attendees to lean into holistic support for issues wider than MSK through prevention and health promotion elements
- Support staff to engage meaningfully with patients on what matters to them, at the same time providing them with an opportunity to step outside of 'business as usual' to address the multifaceted needs of patients more effectively
- Provide staff with an opportunity to connect with colleagues and seek to improve issues with staff morale and burnout.

Ultimately, the CAD initiative aims to improve MSK patient outcomes and experience through an integrated 'one stop shop' of relevant services and support based closer to where patients are.

Six CADs were delivered in 2023 across three sites in Crawley, Horsham and Brighton. Everyone on the relevant Sussex MSK Partnership waiting list was invited to attend the CADs in Crawley and Horsham; the Brighton events were more focused, with only patients with hip and knee complaints invited to attend.

All the CAD events were held in large spaces in local leisure centres. To support a move away from the medicalized model, walls and barriers within these spaces were removed to create a single shared space for patients and staff to move around easily and enable rapid communication.

CAD attendees were provided a 'passport' on arrival which was used to record key information such as which areas were visited, specific notes and advice provided, and any other relevant information such as exercises or links to additional information. Providing the patient with a passport to document their own CAD journey and make notes helped them to take an active role in their care and provided them with a record of their key take-aways and actions on the day.

Each attendee started the CAD session with a 'What Matters To You' session, a critical facet of the CAD approach, during which the attendee and clinician discussed the attendees needs and goals. The conversation held in the 'What Matters To You' session was framed as a health coaching conversation, using the T-GROW model⁷. The outputs of this conversation determined the next steps needed. This may include one-to-one assessment, access to rehabilitation specialists or advice and guidance activities. Attendees were encouraged to move around the hall and spend as much time as they needed with each and all of the services they required. Similarly, staff had no time limits on how long they could spend with each attendee, encouraging them to invest the time each individual needed with them to meet their needs and goals.

In addition to the clinical areas, a health promotion hub, supporting prevention and healthy lifestyles was also available, providing diabetes testing, blood pressure, cholesterol testing and height and weight measurement. Alongside this was an opportunity to access a range of community services such as Citizens Advice, DWP, women's health groups and carer support. These elements were key in providing the opportunity to support CAD attendees with issues beyond their MSK condition, but that may impact on their ability to manage it.

⁷ Wilson, J., & Curtis, R. (2018). *The Coaching Manual: The Definitive Guide to the Process, Principles and Skills of Personal Coaching* (4th ed.). Pearson.

Throughout the CADs evaluative data was collected with a focus on who attended and which services they utilised. Attendees were 'checked in' and 'checked out' of the CAD, key data collection points. At checkout some were provided an opportunity to provide feedback immediately in the form of an interview. Attendees were also followed up with a survey. Staff from the CAD events were also surveyed.

Purpose of this report

What is included

This document sets out to report findings from readily available evaluative data collected at the time of the Community Appointment Days, with a view to assessing the following key evaluation questions (KEQs):

- **KEQ:** Does CAD have an impact on future service utilisation for those people that have attended?
Rationale for inclusion: One of the primary purposes of the CAD initiative is to understand what matters to patients and use this as the basis for defining the most appropriate course of action to enable individuals to meet their personal goals. It is anticipated that targeting intervention and self-management support in this way will help to reduce the likelihood of patients being referred to multiple services in the future and reduce reliance on services, from the NHS perspective. Therefore, it is hypothesised that future service utilisation by patients that have attended CAD will, on average, be lower than for those who have not.
- **KEQ:** How do patients experience CAD?
Rationale for inclusion: CAD has been designed to have patients' needs and concerns at its heart. The layout and processes for attendance, including engagement with multiple specialisms and community-based providers, was designed to be as seamless as possible in a 'one stop shop' paradigm. Whether these intentions were successful can only be measured through the exploration of the patients' experience of the CAD, how their expectations were met and whether they felt their needs were really listened to and acted upon. In addition, there will be lessons to learn for future implementation of CAD through the exploration of patients' views and experience.
- **KEQ:** How do staff experience CAD?
Rationale for inclusion: The success of any initiative is dependent on the staff delivering it. CAD brings together many staff from different disciplines and geographical areas and represents a very different way of working. The experience of staff in delivering the CAD is a critical element in understanding the success of CAD and its sustainability and there will be lessons to learn for future implementation of CAD.
- **KEQ:** How well is CAD adopted/attended?
Rationale for inclusion: Understanding attendance and any differential in terms of demographic (e.g. age group, ethnicity) or clinical (e.g. condition, site of problem) factors will help explore the likely success of the CAD initiative in helping address patients' needs and help to highlight any inequity that may need to be addressed in future iterations.

- **KEQ:** Are people who attend CAD able to explore broader issues that may impact their health and wellbeing?
Rationale for inclusion: A primary purpose of the CAD initiative is to enable patients and their care teams to look beyond the initial clinical need and assess the requirement for additional health, wellbeing or practical support from community or VCSE providers in order for them to meet their personal goals. The ability to access additional support or alternative services is critical to realising this purpose and understanding how this element of the CAD initiative was used will help with identifying barriers and enablers to providing the holistic approach to which the CAD initiative aspires.
- **KEQ:** How does CAD impact inequity?
Rationale for inclusion: The impact of musculoskeletal conditions is not experienced equally across the population. Musculoskeletal conditions are linked to deprivation, age, are more prevalent in women, and disproportionately affect some ethnic groups. Exploring the KEQs outlined above and including sub-group analysis wherever available, it will be possible to have some insight into whether any impact of the initiative have differential effects on different patient groups. This will inform future iterations of the CAD initiative.

Findings are preceded by a methods section which outlines the approach taken for each component of the analysis.

Following an outline of findings, a synthesis of data collected as part of each of the evaluative components is undertaken and interpreted in the context of the evaluation questions and limitations to the approach outlined.

For readers short of time to read the full report, note that a summary of findings is provided on pages 3-5.

As this document is focused on the analysis of available data only, it does seek to identify gaps in the evidence available and makes recommendations with regard to future research and data collection to help supplement the findings outlined here.

What is excluded

No health economic analysis is undertaken as a part of this work. It is anticipated that there may be gaps in the available evidence in relation to specific KEQs; addressing these gaps will form the basis for future recommendations in regard to evaluation of the CAD initiative but will not be addressed through additional data collection as part of this report.

How to read this report

The findings in this report are outlined with the support of data visualisations and, where appropriate, quotes, presented in line with the text to provide the greatest context wherever possible.

Where quotes are used, those with a generally positive sentiment are shown with a blue background, those with a generally negative sentiment have a red background.

Findings have been grouped by key data sources (staff survey, patient surveys and interviews and quantitative data), and then synthesised across them to provide overarching findings and recommendations.

Methods

The data collection and analysis required for this work was undertaken across three key areas. The methodology associated with each of these is outlined in this section, prior to discussion of findings.

CAD patient survey

The patient survey was undertaken at each CAD event undertaken in 2023, six events in total. Overall, 1,301 patients were surveyed. Responses from the survey were transposed to an MSExcel spreadsheet and held anonymously, with randomly assigned participant numbers used to identify the individual responses.

The survey consisted of five questions:

- three questions which together constituted the 'Collaborate Questionnaire'. These questions were closed questions, answered on a likert scale of 0-4, with a focus on the effort put in by the CAD to the collaborative nature of the service being aimed for
- two open text questions soliciting general feedback on positives and negatives

The questions posed in the survey are included at Appendix A.

Analysis of the CAD patient survey data was carried out using R version 4.3.1 and MSExcel. LiGRE was used for thematic analysis of anonymised qualitative feedback for the relevant open text questions.

CAD patient interviews

Short patient interviews were undertaken at the first two CAD events on an opportunistic basis. In total 36 interviews were undertaken. These were recorded or noted verbatim at the time of interview and transcribed into word documents. Where necessary, elements of the interviews were redacted in order to maintain anonymity.

Transcriptions were analysed using inductive thematic analysis using a framework method⁸. Inductive thematic analysis involves identifying patterns and themes in qualitative data such as interview transcripts, coding and categorising until no new themes emerge, reaching saturation. Initial categories were posited on the basis of preliminary text mining and sentiment analysis of the corpus but developed and amended in line with the coding and categorisation process. This method ensures a comprehensive understanding of the data, reflecting participants' perspectives and experiences accurately.

Analysis of the CAD patient survey data was carried out using R version 4.3.1, with the "nrc"⁹ and "afinn"¹⁰ sentiment libraries, and MSExcel.

⁸ Gale, N.K., Heath, G., Cameron, E. et al. (2013) Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*, 13, 117

⁹ NRC Word-Emotion Association Lexicon. Published in: Saif M. Mohammad & Peter Turney. (2013), Crowdsourcing a Word-Emotion Association Lexicon, *Computational Intelligence*, 29(3): 436-465 (accessed: <http://saifmohammad.com/WebPages/lexicons.html>)

¹⁰ AFIN-111, under Open Database License (ODbL) v1.0 (accessed: http://www2.imm.dtu.dk/pubdb/views/publication_details.php?id=6010)

CAD staff survey

The staff survey was undertaken in relation to the first two CADs, at Crawley K2 Sport & Leisure centre on the 24th April 2023, and at Horsham's Bridge Leisure Centre on the 18th May 2023. Overall, 71 staff from both clinical and non-clinical backgrounds were surveyed.

The survey consisted of ten questions:

- three questions were descriptive, to ascertain site and role in the CAD
- four questions were closed questions answered on a likert scale with free text for additional comments
- three open text questions soliciting general feedback on positives and negatives

The questions posed in the survey are included at Appendix B.

Analysis of the CAD staff survey data was carried out using R version 4.3.1, and MSEXcel. LiGRE was used for thematic analysis of anonymised qualitative feedback for the relevant open text questions.

Activity and waiting list quantitative data extracts

Data pertaining to invitations and the activity undertaken at CAD events was provided by the Sussex MSK service (HERE). Data was provided anonymously at individual patient level and included key demographic variables, date and site of attendance, outcome of attendance and records of attendance at each of the clinical, 'health hub' and community hub components of the CAD event. Data was transferred in MSEXcel format under a data sharing agreement approved by HERE's Caldicott guardian in keeping with Caldicott principles, the UK GDPR and other relevant legislation and guidelines for the purpose of service evaluation.

Waiting list data was sourced from publicly available returns; the Community Health Services (CHS) SitRep¹¹ collects monthly data on waiting lists and waiting times for Children and Young People's (CYP) and Adult's community health services. Providers submit aggregated information for service lines, irrespective of the number of ICBs or regions they provide services under. This data is published as management information, which is collected on a rapid turnaround basis, allowing only minimal validation to be undertaken and as such should be viewed with the requisite caution.

In addition to the data analysed as part of this review, high level activity figures from internal Sussex MSK Partnership reporting have been included in discussion where relevant. Note that these are general figures and have not been analysed as part of this review and are included for context and discussion only.

Analysis of the CAD activity and waiting list data was carried out using R version 4.3.1. Waiting list time series data was analysed using statistical process control techniques¹². This approach utilises control charts to provide insight into variability and stability over time and help identify trends, shifts, and unusual patterns.

¹¹ Community Health Services Waiting Lists. Accessed: <https://www.england.nhs.uk/statistics/statistical-work-areas/community-health-services-waiting-lists/>

¹² NHS England (2019) Making Data Count: Strengthening Your Decisions. London. (accessed: <https://www.england.nhs.uk/wp-content/uploads/2019/12/making-data-count-strengthening-your-decisions.pdf>)

Findings

CAD patient survey

A total of 1,301 patients were provided the CAD patient survey, across six CAD events. 182 patients chose not to complete the survey, giving a response rate of 86%. Not all remaining 1,119 respondents completed all aspects of the survey; response rates for individual components are given in more detail below.

Response rates and numbers of responses included in analysis for each event are shown in table 1.

Table 1: Patient survey responses, where respondents completed at least one elements of the survey, by event

Event venue	Date of event	Response rate	Patient survey responses
Crawley- K2 leisure centre	24/04/2023	72%	345
Horsham - The Bridge Leisure Centre	18/05/2023	75%	339
Crawley- K2 leisure centre	16/10/2023	100%	169
iCAD Brighton	31/10/2023	100%	142
iCAD Brighton	01/11/2023	100%	105
Horsham - The Bridge Leisure Centre	07/12/2023	99%	201

Collaborate Questionnaire

Forty-eight patients did not complete any of the Collaborate Questionnaire questions, giving an overall response rate for all three components of 82%.

Descriptive statistics for each component answer, for all events, are given in table 2.

Table 2: Descriptive statistics for answers to three Collaborate Questionnaire questions

Question	N	Average	Min / Max	Std deviation
How much effort was made to help you understand your health issues?	1,070	3.74	0 / 4	0.50
How much effort was made to listen to the things that matter most to you about your health issues?	1,071	3.80	1 / 4	0.46
How much effort was made to include what matters most to you in choosing what to do next?	1,071	3.75	0 / 4	0.53

The distribution of scores was very skewed with the majority of respondents scoring 4 for each question. The questions with the most top '4' scores was 'How much effort was made to listen to the things that matter most to you about your health issues?' with 836 (83%) of respondents scoring at the top of the scale.

More negative scores (0-2) had low frequency, accounting for between 2.3% - 3.6% of responses. The question with the most frequent, but still very small, low scores was 'How much effort was made to include what matters most to you in choosing what to do next?', with 23 (3.6%) scoring 2 or less. Figure 1 shows the distribution of scores across each of the three questions.

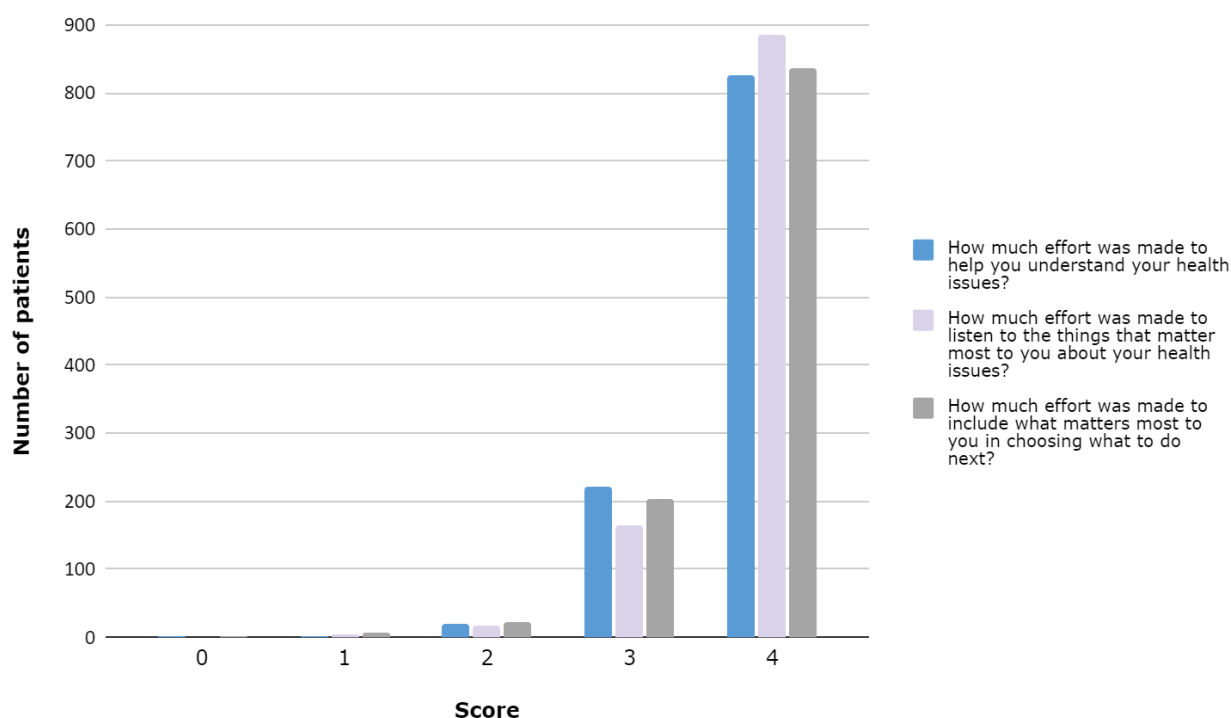


Figure 1: Distribution of scores for each question in the Collaborate Questionnaire

Across all three "Collaboration Questionnaire" questions, the mean aggregate score was 11.3 out of a maximum attainable 12. There were negligible discrepancies in this mean aggregate score between the events, with the minimum being 11.0 and the maximum being 11.44 (see figure 2). There is some evidence to suggest that mean scores increased over time, potentially reflecting ongoing enhancements as feedback was incorporated and processes were refined, and working methods were adapted. Nevertheless, the second iCAD Brighton event had the lowest mean score and deviates from the trend.

Average total score on Collaborate Questionnaire by event

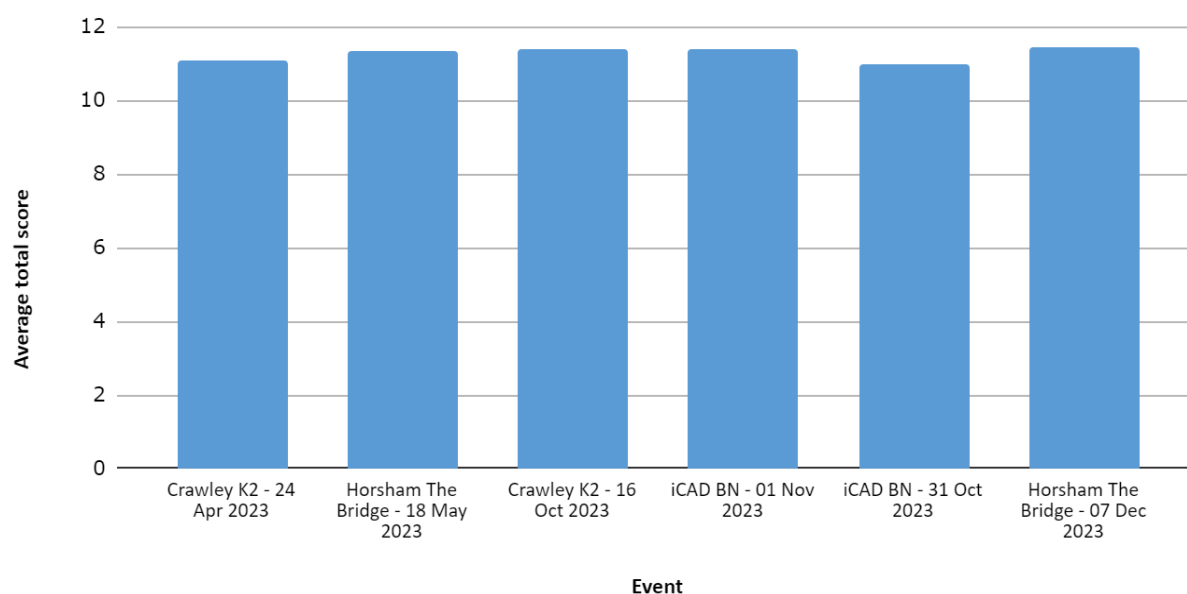


Figure 2: Average total score on Collaborate Questionnaire split by event

The average scores and variation between events for each individual question was again very small; the patterns and trends for each individual question mirror the overall average total score results.

These responses show that, overall, respondents felt that effort had been made to help them understand their health issues, that effort had been made to listen to what mattered to them and that effort was made to include what matters to them when making decisions about future care. This is a positive endorsement of one of the key stated purposes of the CAD initiative, 'to do things differently that supports our population and enable them to take an active part in their care AND support them with what matters most to them'.

Open text feedback

Two open-ended questions were posed to enable patients to articulate their positive and negative perceptions of the CAD program they attended. Of the respondents who completed at least one element of the survey, 154 did not respond to the open-ended question 'What did you like? Which area did you find most useful?' resulting in an overall response rate of 74%. Additionally, 309 respondents did not respond to the open-ended question 'What would you change?' resulting in an overall response rate of 62%.

The first feedback question was overwhelmingly positive and reflected on a number of key themes:

- **High quality, understandable and useful advice and guidance;** much of respondent's feedback was on the helpful information and guidance they had been given, pertinent to their needs. A number of respondents reported having 'in-depth' advice, coupled with well explained guidance, particularly in relation to exercises to undertake at home.

"Everything was done perfectly well. [The physiotherapist] was exceptionally explicit. He listened well, explained everything and I felt reassured. All other staff starting from [the] main entrance were very helpful too..." - Patient at iCAD BN, November 2023

- **Being listened to and having the time to tell their story;** respondents reported finding staff easy to talk to and had a sense of genuine interest in their concerns and wellbeing. This, coupled with having the time available to tell their story, with personal context, provided respondents felt listened to throughout the CAD experience.

"Amazing to be talked to and considered as a whole, instead of loads of different appointments" - Patient at The Bridge, Horsham, December 2023

"Fantastic advice, explanation and assessment from [the podiatrist]. Really listened to my son and explained everything in depth. Great service."- Patient at K2, Crawley, April 2023

- **Atmosphere and environment;** respondents reported a warm, welcoming, attentive and friendly atmosphere that felt more comfortable than traditional (hospital based) settings. The positive attitude of staff was a factor frequently cited by respondents. The 'face-to-face' nature of the CAD was also noted as a particular strength of the event.

"I liked the atmosphere and behaviour of staff. Everyone was lovely and anxious to help me. I liked both areas I was sent to, especially rehab because the lady there was extremely kind and went above and beyond with trying to help me." - Patient at K2, Crawley, April 2023

- **Concept;** the concept of a 'one-stop', thorough review of individual issues by multiple professionals, including consideration of relevant comorbidities, and on-the-spot classes or treatment was a critical benefit identified by respondents. The fact that this was available without multiple appointments and attendant waits was a key factor.

"What a great idea to have all services in 1 place that I could attend. I left having discussed my issues, my options and with a plan of action. In 1 appointment, instead of waiting for multiple with different professionals." - Patient at iCAD BN, October 2023

The second open text question, focused on what patients would change about the day, included a large number of responses that suggested that no change was required based on their experience. Approximately 50% of responses to this question had a positive sentiment, rather than offering any critique or suggestion for improvement; almost 200 respondents (n=192) simply answered “nothing” in response to the question.

Where changes had been suggested a number of key themes emerged:

- **Advance information on what to expect;** many respondents felt they had been ill prepared for the nature and format of the event and had been unaware that it was not an appointment of fixed duration. Specifically, the text messaging used as part of the communication with patients to book slots did not specify the amount of time required.

“More pre-appointment information about the nature of the day. I thought it was a 30 minute consultation. I would have liked to have been free to spend more time here today, but I had another commitment elsewhere.” - Patient at iCAD BN, November 2023

- **Consideration of the impact of crowds and noise;** the CAD events were held in a big space with lots of people moving about constantly. An emerging theme from feedback was that this had been difficult to cope with for a number of patients attending, and more generally came as a surprise to patients who hadn’t known what to expect.

“There needs to be more warning about what to expect. I believe someone with anxiety, mental health or a neurodiverse condition would really struggle if they were not prepared for the big and busy environment.” - Patient at K2, Crawley, October 2023

- **Capacity pinch points and waiting times;** bottlenecks at specific points in the process of the CAD was a source of frustration, particularly when this involved waiting. In early CAD events the initial waiting after checking in was source of negative sentiment, with suggestions that a numbering system was used to avoid queue jumping.

“Could do with knowing that it's not an appointment time and to bring a book and that waiting times are long.” - Patient at The Bridge, Horsham, May 2023

“Numbers would be helpful when you first arrive to be seen as lots of people waiting and no one to say who is next.” - Patient at The Bridge, Horsham, December 2023

CAD patient interviews

A total of thirty-six interviews were undertaken. 60% of interview participants were female. 53% of interviews were with respondents at the first Crawley based CAD held at K2 leisure centre.

A general sentiment analysis of the whole corpus showed general sentiments as overwhelmingly positive. Positive sentiments included 'anticipation', 'joy' and 'trust'. This was balanced, but to a much lesser extent, by some negative sentiment which reflected 'fear or concern'. The sentiment analysis also showed that interviewees had expressed 'surprise'.

Further individual analysis of each of the thirty-six interviews led to the identification of eight key themes that emerged consistently across the entire corpus, providing valuable context for interpreting the results of the sentiment analysis. Many of the themes are interrelated but emerged individually and consistently enough to be considered separately. Each of the themes are briefly described below with supporting quotes.

Helpful and informative advice for my specific problem

Interviewees were very satisfied with the advice and guidance they received and felt it was personalised to their specific needs and issues. There was particular feedback from many interviewees that the ability to talk about more than one problem at a single session, for example a back issue *and* a hand issue, meant that the advice they received was tailored to their particular abilities or limitations.

"[the physio] asked me if there was anything else that was troubling me, which was good, and then she sent me somewhere else" - Female interviewee from K2, Crawley CAD, April 2023

Practical things to do or try out & a clear plan of action

One of the strongest themes emerging from the interview transcripts was the practical nature of the advice and guidance given and clarity on how to apply that in the individuals' context. Interviewees reported being very pleased with advice and practical demonstration of exercises to undertake, with supporting resources that would enable them to continue them at home or around their work. These practical outputs were of high value to the interviewees who felt they were leaving the CAD with clarity on next steps and the ability to address their issues.

"now I know what I'm going to need post surgery and what I can do beforehand to help" - Male interviewee from K2, Crawley CAD, April 2023

"The best thing was the exercises being [shown] how to deal and bend, lift and treat, treat it and you know, trying to have a life with it" - Female interviewee from K2, Crawley CAD, April 2023

Access to multiple areas and specialisms based on what I need and what matters most to me

Interviewees were particularly pleased with the ability to visit multiple areas and specialist practitioners to help them work through their particular problem or problems. The 'one stop shop' approach was felt to not just save time, but also enable them to talk about themselves in an holistic sense, in the context of their own lives and challenges and what they want to be able to achieve.

"I like that everything's in one place, rather than trying to get hold of a doctor, then waiting and being passed along, I like the, and I like the well-being section. You wouldn't normally think of something like that for back pain." - Female interviewee from K2, Crawley CAD, April 2023

"...you have different people here to talk about different aspects of what your issues are." - Female interviewee from The Bridge, Horsham CAD, May 2023

Not sure what to expect

The majority of interviewees reflected that they did not know what to expect of the CAD. Some of this reflection was positive in that their expectations of a 'normal' appointment was far exceeded by something more interactive and holistic, but other reflections were more negative, suggesting concern or worry ahead of the CAD. This is the main theme reflected in the findings in the sentiment analysis around 'surprise' and 'fear or concern'.

"I wasn't sure what to expect but came here and was pleasantly surprised, I thought it was very well organised and I think I got around fairly quickly.." - Female interviewee from K2, Crawley CAD, April 2023

"I wasn't sure what to expect and thought it was a waste of time coming here.....because I didn't think anyone would listen and take a lot of notice and just drop you off with painkillers perhaps." - female interviewee, The Bridge, Horsham CAD, May 2023

Improved experience over usual care

During the interviews, participants discussed their experiences of the CAD in contrast to their usual care. They drew particular comparisons with regard to the amount of time individually allocated to them and the amount of time spent waiting for treatment or advice. This 'time allowed' comparison was reflected in the ability of many participants to discuss multiple issues within what was perceived as a "single appointment." However, it was also discussed in the context of what mattered most to them. Participants reflected that they often lacked sufficient time in a typical GP or consultant-led appointment to discuss their problems comprehensively.

Waiting times were also an issue that CAD improved upon in comparison to usual care. Many participants had been waiting several months to be seen by the musculoskeletal (MSK) service, often on multiple lists for various problems. They also indicated that they had to wait, frequently without any meaningful guidance or information, between appointments as they progressed through a clinical pathway.

"...what matters to [each individual] is taken into account really, so yeah, that was nice because sometimes when you go the GP, you know, they will try to fix a problem but they don't usually ask what matters to you, they haven't got time." - Female interviewee from The Bridge, Horsham CAD, May 2023

"...the initial response from the GP...was that there could be 10 months to a year before you're seen. So you doing this, what a difference.."- Male interviewee from The Bridge, Horsham CAD, May 2023

Self confidence, efficacy and management

A significant part of the aims of the CAD initiative was to enable patients to take an active role in their care. This aim was supported by emerging themes around the ability and desire to self manage and a sense of control of their condition and concerns. In addition, the interviewees gave a sense of a growth in confidence, in terms of being able to discuss their own viewpoints and needs, as opposed to feeling unable to communicate these to professionals.

"It puts you in control and I think that's really so much more understanding of what your needs are rather than what they think you need." - Female interviewee from K2, Crawley CAD, April 2023

"I feel pretty good because I know this problem has affected my walking so it's giving me things to Do whilst I can't do the walking with an aim to increasing the walking" - Female interviewee from K2, Crawley CAD, April 2023

Feeling listened to

This critical theme emerged from the majority of interviewees and was often accompanied by reflections regarding self management and confidence, and comparisons to usual care. Interviewees felt not only that they were given time to explain their condition(s) and concerns but also that this was listened to and taken into account when advice, treatment or onward referral was given. This could be seen as a foundation to the stated aim of giving patients the opportunity to take an active role in their care.

"It's all done, you're getting answers immediately, and I've seen people here and I felt like I was taken more seriously today than I have been in a long time." - Female interviewee from The Bridge, Horsham CAD, May 2023

"I felt very listened to, which for obviously health can be quite complicated and you can find yourself down a big long rabbit hole of explaining your condition, and not feeling that you're getting your point across very well, but I felt today it was kind of a summary of what was happening but I was really, really listened to." - Female interviewee from The Bridge, Horsham CAD, May 2023

Trust in professionals who know how to look after me

The initial semantic analysis highlighted an emerging theme of 'trust' across the whole corpus. This was reflected most strongly in interviewees feedback on the individuals they saw during the CAD and the nature of their interventions. Linked to 'feeling listened to', it was clear that interviewees felt staff really engaged with their concerns and provided them with tailored and relevant advice, guidance and treatment. A number of interviewees reflected that the multidisciplinary nature of the event meant that, collectively, the people in the room knew how to look after them as a whole person. There was a strong sense of trust in the process and the individuals who were perceived as 'going the extra mile' (often when compared to usual care).

"I didn't feel like he was just going 'what do you want to do I don't care', it was like a what do you want to do because these are your options." - Male interviewee from The Bridge, Horsham CAD, May 2023

The eight themes outlined above were consistent between the two sites covered. Neither site had any notable variation in the volume or nature of the themes emerging.

However, there were some notable differences between genders in terms of some themes identified. Notably, 45% of the female interviewees mentioned improved experience over usual care and 41% of mentioned 'feeling listened to'. This was much lower in male interviewees, 28% and 14% respectively. Similarly, 77% of female interviews included the theme 'practical things to do or try out & a clear plan of action', compared to just 50% of males.

CAD staff survey

A total of 71 individuals participated in the CAD staff survey. Among those who responded to the question regarding the specific CAD event they were providing feedback for (39.4%), the majority provided feedback exclusively on the Horsham event held at the Bridge Leisure Centre (67.9%). Notably, only one individual provided feedback on just the Crawley event at K2 leisure centre (3.6%), while the remaining respondents provided feedback encompassing both events (28.6%).

Participants primarily held clinical roles, comprising 69% of the sample. Within this group, the majority hailed from physiotherapy backgrounds, encompassing both advanced and first contact practitioners. Additional professional clinical disciplines represented in the survey included nursing, osteopathy, and podiatry. The remaining respondents identified themselves as "non-clinical," including administrative personnel, IT support staff, patient care advisors, and healthcare builders.

The survey respondents were relatively equally distributed across each component of the CAD. Figure 3 below illustrates the proportion of respondents who indicated that they worked at each stage of the journey through the CAD. It is important to note that respondents were able to select multiple areas, which resulted in the overall percentage totaling more than 100%.

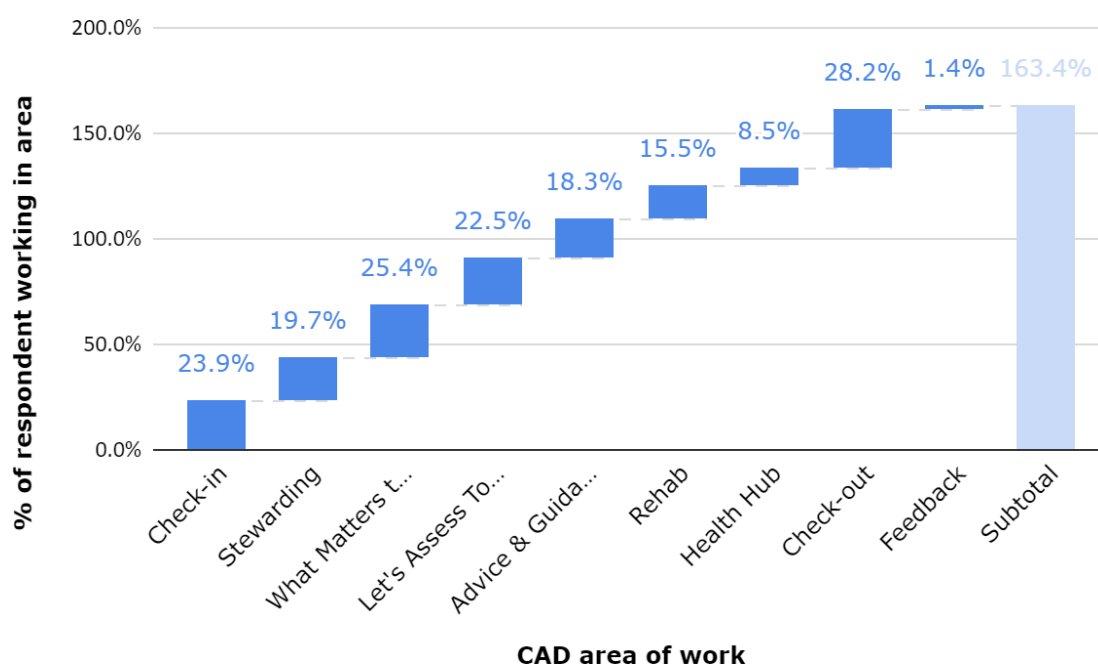


Figure 3: Proportion of staff survey respondents who worked in each of the CAD areas

These results show that the staff survey was a good representation of both the makeup of the staff running the CADs on the day, and the experience across all aspects of the event.

The specific closed question on how well the day was organised was met with a broadly positive response; 90.1% of respondents indicated that the CAD had been extremely well or very well organised (see figure 4a).

From the free text element of this question, key themes emerged, both positive and negative. These primarily centered around:

- operational issues with wifi and IT
- smooth and well-planned flow of patients around the event
- the work that went into planning the day was acknowledged as factor in the smooth operation of the CAD. There was however some feedback that pre-event briefing for staff and better explanation of what to expect would have been beneficial to improving the organisation on the day.

"The hard work beforehand in the months and weeks before the Crawley and the Horsham CAD paid off" - staff survey respondent

The staff survey question pertaining to how supported respondents felt on the day was also responded to positively; 91.5% of respondents indicated that they had felt extremely or very supported on the day (see figure 4b).

From the free text element of this question, key themes emerged, largely positive. The most prominent theme was in relation to the team ethos and the willingness of the wider staff team to help each other on the day in a responsive way, demonstrating collaboration across professional groups whenever it was needed. Crucially, there was a sense among staff on the day that they were able to ask questions.

"I felt I was able to ask questions to anyone when I wasn't sure of something and everyone was very supportive" - staff survey respondent

This was in spite of staff coming from different geographical areas and many not having met before.

"Despite not having met most of the team before everyone was very kind and encouraging" - staff survey respondent

There was however one specific, more negative, theme that emerged with regard to support to take breaks in a timely way and ensuring that there was adequate cover in particular areas, particularly the 'Lets Assess Together' and 'What Matters To You' areas, when this needed to happen.

"[I] felt pressure to get back to WMTY station during break. Was not advised on when to take a break" - staff survey respondent

Taken together, these two questions indicate that staff felt the day was well organised and they felt supported to deliver the event. Nevertheless, there are opportunities for improvement.

How well did you think the day was organised?

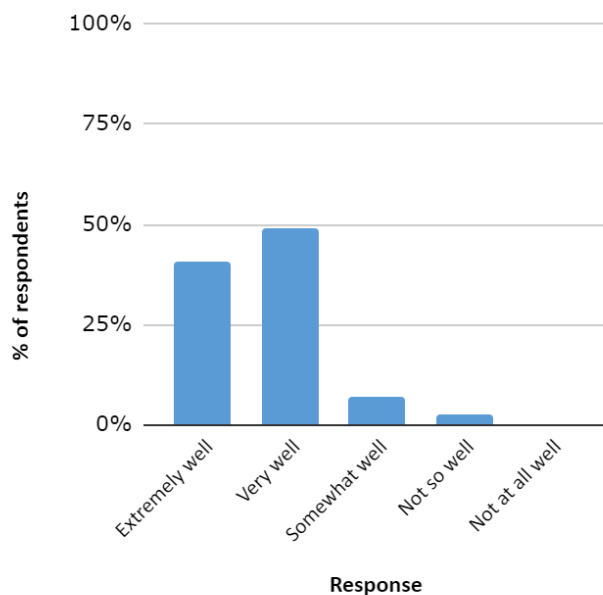


Figure 4a: responses to staff survey Q4

Did you feel supported during the day?

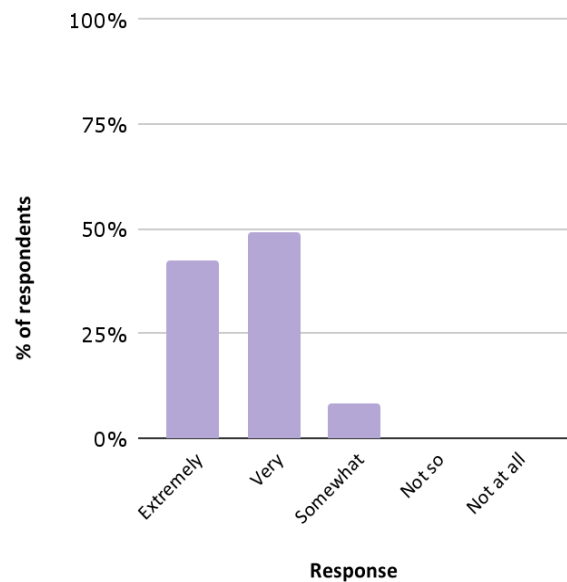


Figure 4b: responses to staff survey Q5

Questions focusing on the extent to which the CADs met their intended purpose from both a patient and a staff perspective were positively responded to. Survey respondents generally

felt that the stated purpose “*To do things differently that supports our population and enable them to take an active part in their care AND support them with what matters most to them*” had been met well, with 90.1% responding ‘extremely well’ or ‘very well’ (see figure 5).

In terms of the qualitative feedback around this question, the key themes emerging were that this purpose had been met through spending time with patients and ensuring they felt listened to. This was felt to give rise to improved patient activation and a sense that patients were able to connect to a wider range of support than would otherwise have been available in a traditional appointment.

One of the purposes for the day was "To do things differently that supports our population and enable them to take an active part in their care AND support them with what matters most to them." How well do you think we met this?

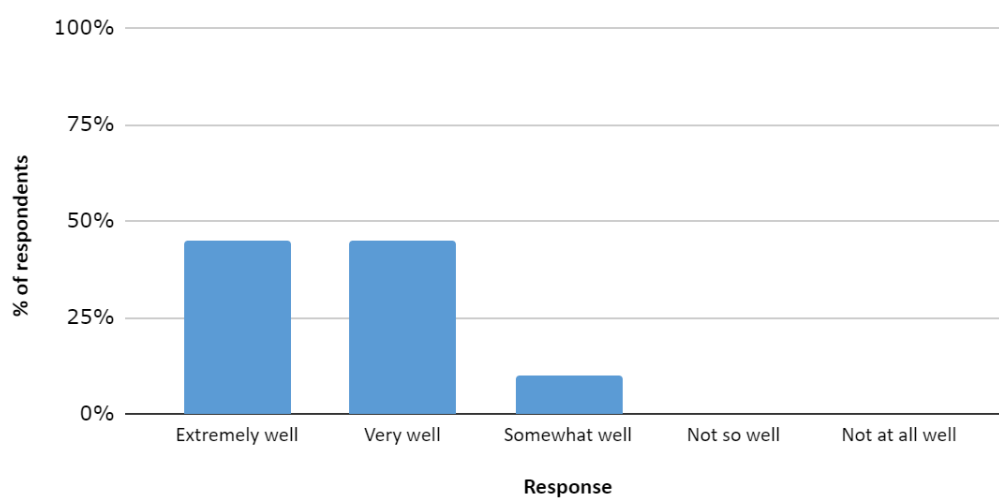


Figure 5: Responses to staff survey question 6

"It was so good to give spend time with patients (not feeling rushed) and to be able to offer rehab in addition to advice and guidance all in one appointment." - staff survey respondent

"Patients commented that the day was an excellent way for them to see what was available and for them to actually be able to take charge with their care. A patient got very teary and said they thought the day was brilliant because not only did they feel heard they felt that they could seek out agencies/help for what they felt was relevant to them." - staff survey respondent

Not all feedback with regard to this question was positive, with some respondents reflecting that perhaps more could have been done to explicitly support self-management, and that sometimes advice and guidance was too generic, and patients may be missing out on truly personalised care.

"...patients who were sent to advice and guidance would have only received generic advice as they would not have had a working diagnosis.....this changes the nature of the advice which is not personalised care for the patient." - staff survey respondent

The purpose with more of a staff focus was for the CAD to provide "An opportunity to step out of your normal day, be supported by each other and work together whilst having sight of what is available in the community to support beyond just an MSK problem". Once again, staff survey respondents replied positively when asked whether this purpose had been met (see figure 6) with 80.3% answering 'extremely well' or 'very well'.

One of the purposes for the day was "An opportunity to step out of your normal day, be supported by each other and work together whilst having sight of what is available in the community to support beyond just an MSK problem." How well do you think we met this?

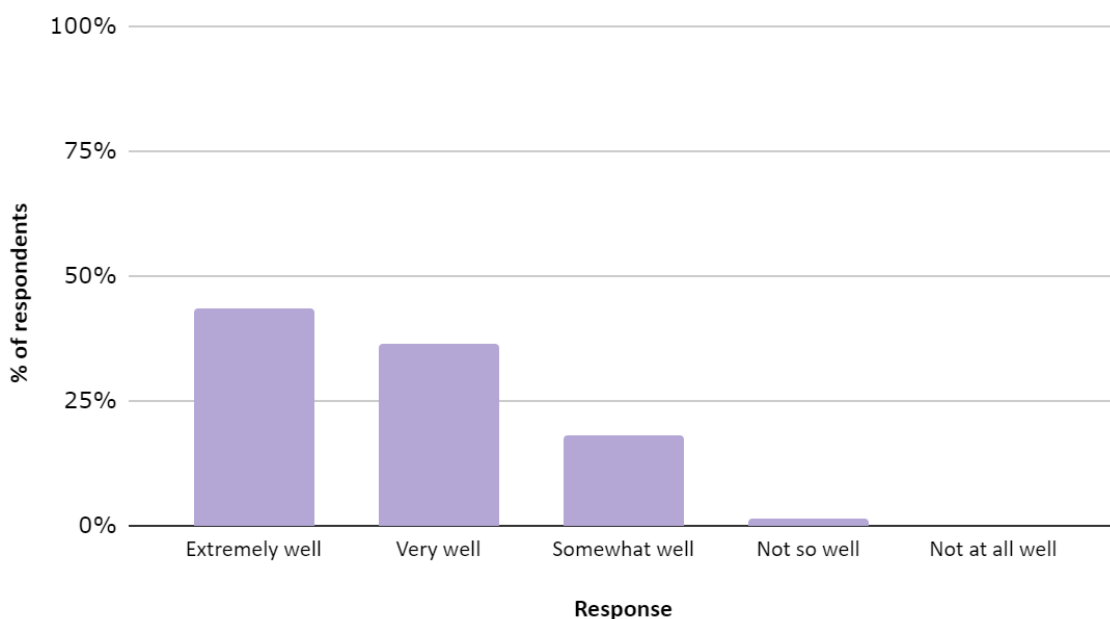


Figure 6: Responses to staff survey question 7

Whilst this is strongly positive, the response is more muted than previous questions. Qualitative feedback showed positive and negative themes emerging. From a positive perspective staff generally seemed to enjoy the experience of the CAD, feeling they worked well together, and able to see examples of different staff groups across multiple geographies acting as one team. A change of environment was also noted as positive, with a sense of real energy and feeling part of something new and exciting that really added value.

"I saw colleagues from the south and the north working together and there was a real sense of a shared purpose and experience. I got the opportunity to see clinicians doing what they do best but in a different environment and I had a few conversations with clinicians who were looking forward to the day supportive of it and there was a positive energy about this." - staff survey respondent

"I loved how easy it was to quickly get and give info across specialities. What would normally take weeks of task/emails happened so quickly. So lovely to all be in the same place and also not be stuck behind a computer all day!" - staff survey respondent

The negative themes revolved around time pressure and concern with regard to service availability. On time pressure, there were clearly specific areas of the CAD which were particularly busy, which gave rise to intense and pressured working conditions ('Lets Assess Together' was an example given more than once). This led to a perceived lack of ability for staff to provide the 'different' service they had been hoping for. There was also some reflection that the community service providers/partners were either poorly represented or unable to stay for the whole session. This gave rise to inequity for those attending later in the day.

"This [purpose] was generally met extremely well but not available for all of the patients. We very much appreciated the time given by some of the services and community partners but unfortunately some of them were not able to stay for the whole day. In my experience this meant that some patients who attended later in the day who had identified areas that were important to them and managing their health condition did not have access to all of the services that may have been able to help with this" - staff survey respondent

"We worked well together in 'let's assess together' but there was not much time as we were constantly moving onto the next patient. I felt like I was working in a triage clinic." - staff survey respondent

The final questions in the staff survey were open text and seeking general reflection on what went well and what could be improved. There was a wide range of comments and reflections for both of these questions, with key themes emerging for both:

What did you like best about the event?

- **The value delivered for patients;** providing a chance for patients to explore a wide range of options and speak to a wide range of professionals all in one go. Respondents also felt that patients were provided with flexibility and able to really take the time to explore their needs and what mattered to them. Comparisons to 'usual care' were also made, with respondents noting that the CAD model saved patients a considerable amount of time in terms of waiting and numbers of appointments.
- **Staff connections;** meeting and working in a collaborative environment with colleagues and a sense of being able to exchange skills and knowledge rapidly.

Respondents also reported feeling a sense of connection and purpose that would necessarily be the case in more traditional settings.

- **Atmosphere;** respondents reporting a vibrant and ‘buzzing’ atmosphere that helped keep energy up. The sense of connection previously mentioned added to this, with respondents reflecting on a collegiate and co-operative atmosphere where people could all pull together.

"....some people got the care they needed within an hour which in our usual process would've taken over a year. The sense of buzz camaraderie and energy to the day was unsurpassed. The smiles!" - staff survey respondent

*"Hands down it was the team. My experience....has taught me that no matter what bells and whistles you plan for an event, no matter the content, the idea, none of it has value without the team to execute it. The team was amazing and that's why I think the event was amazing.
" - staff survey respondent*

What would you have changed?

- **Administrative processes and flow;** there was reflection from respondents that the layout of the CAD was not always intuitive and that waiting areas could get overcrowded. The checkout process occasionally proved difficult if an individual patient had visited a lot of areas.
- **Preparation and training time;** many respondents felt that there had not been adequate time provided before the event to familiarise themselves with how the CAD would work on the day and what was expected of them, and that the training provided did not necessarily include all staff members (e.g. admin team). Others noted that training should cover as many CAD areas as possible to enable a greater degree of rotation in response to demand. Similarly, advance information to patients was also seen as a potential improvement to be made.
- **Greater responsiveness to staffing levels;** respondents noted that there were specific areas in the CAD that were busier than others ('Let's Assess Together' and 'What Matters To You' were specifically mentioned a number of times). Greater flexibility in addressing these areas either in terms of the distribution of staff, or absolute numbers of staff put on those areas in the first place.
- **Timings of the day;** this theme largely reflected on the timing slots for patient arrivals, noting that hour slots meant distinct 'waves' in terms of demand. Additional time before patients arrived was also a topic for reflection, allowing more time for briefing and checking technical set up. Finally, it was noted many of the community partners had been unable to stay the whole day and that there was a sense of things 'winding down' at the end of the day when patients were still in the event.

"The project prep beforehand needed more of the right experts in the room earlier on - we could have avoided some fraught last minute actions. Let the experts decide if they need to be involved please don't guess on their behalf. We also should have included an Admin rep in the briefing in Crawley this group felt devalued and there was important collaboration required between the clinicians and administrators.." - staff survey respondent

"The distribution in the teams needs improvement as some teams were much busier than it was anticipated." - staff survey respondent

Demographic, activity and waiting list analysis

The quantitative dataset for the CAD events included information for 1,768 patients, across three CAD sites and six CAD events. Table 3 below provides the number of patients in the dataset against each site and date.

Table 3: Number of patients invited to each CAD

CAD site	Event dates	Patients invited
K2 leisure centre, Crawley	24th April 2023	333
	16th October 2023	300
The Bridge leisure centre, Horsham	18th May 2023	328
	7th December 2023	344
Moulsecoomb leisure centre, Brighton	31st October 2023	235
	1st November 2023	228

The map shown in figure 5 illustrates where patients were resident at the time of invitation. The majority of invitees are clustered around where the CAD event locations (Crawley, Horsham and Brighton) with notable clusters in the southern part of Reigate and Banstead (Redhill, Reigate, Horley) and Southwater village, south of the main Horsham conurbation.

The points on the map shown in figure 7 indicate deprivation decile (darker blue = more deprived) and provides some indication of the differences between different areas. For example, Horsham invitees are generally from less deprived localities, compared to Crawley, whilst Brighton is more mixed. More detailed analysis of this and other demographic variation is provided below.

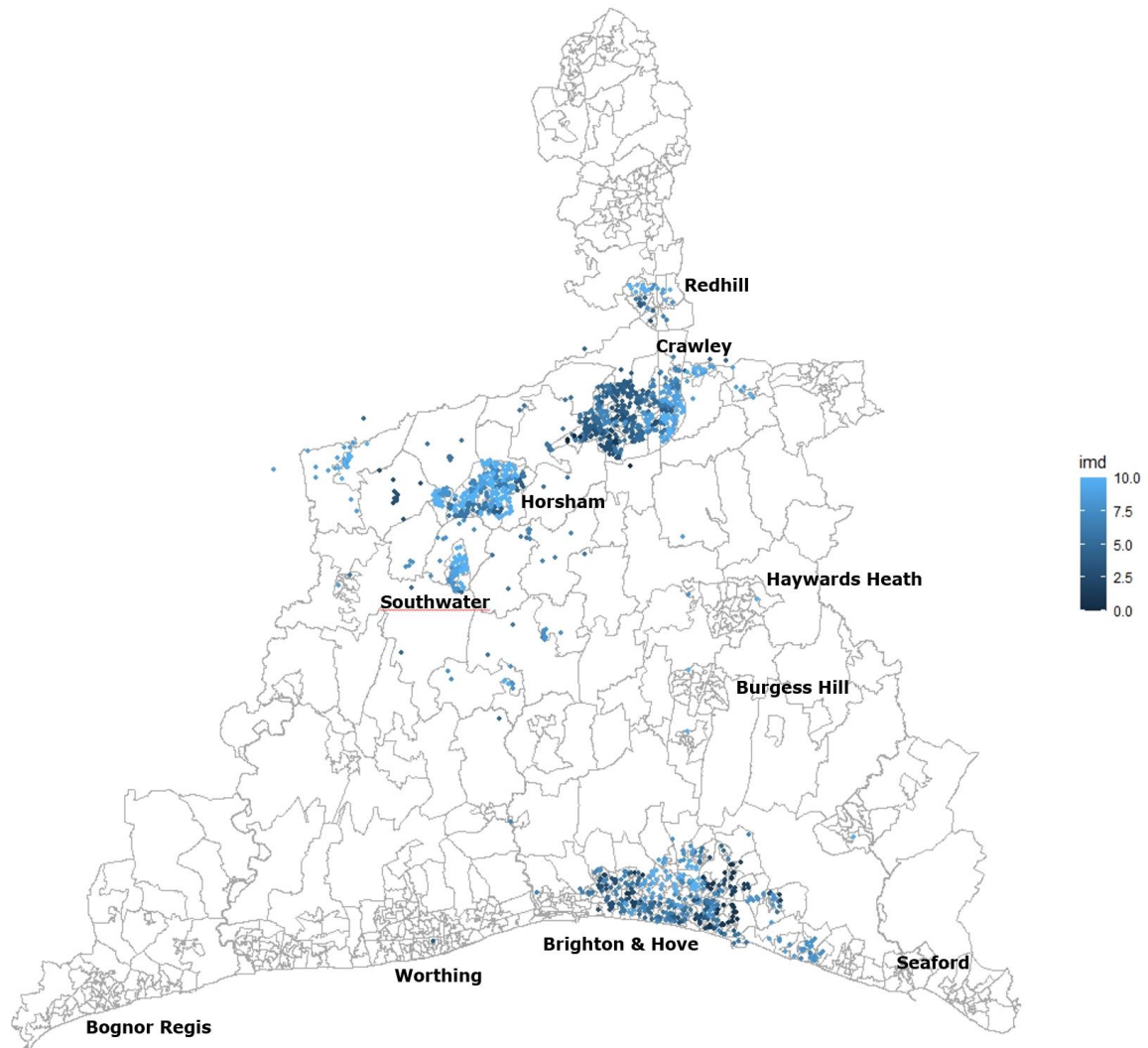


Figure 7: Patients invited to CAD services by residence; Sussex and parts of Surrey shown

The figures in table 1 and plotted in figure 5 represent the totality of the patients *invited* to a CAD event, as opposed to attendees which is explored in more detail below.

Demographic breakdown

Age

The average age for patients invited to the CAD events was 56.4 years of age. This varied slightly by CAD site; invitees for K2 leisure centre CAD events in Crawley were on average 5 years younger than those invited to Moulsecoomb in Brighton and 4.4 years younger than those invited to The Bridge in Horsham. The general distribution of invitees across age groups (see figure 8) skews younger in Crawley, with a greater proportion of under 60s compared to Horsham. For the CADs held at Moulsecoomb the age distribution was quite different

compared to Crawley and Horsham with a clear peak between 55-69 years of age. This is likely reflective of the comparatively narrow focus of clinical need (see 'reasons for coming' below).

In the case of Crawley and Horsham CAD events this age distribution is broadly reflective of the lower median age of residents in Crawley compared to Horsham and potentially its poorer health status¹³.

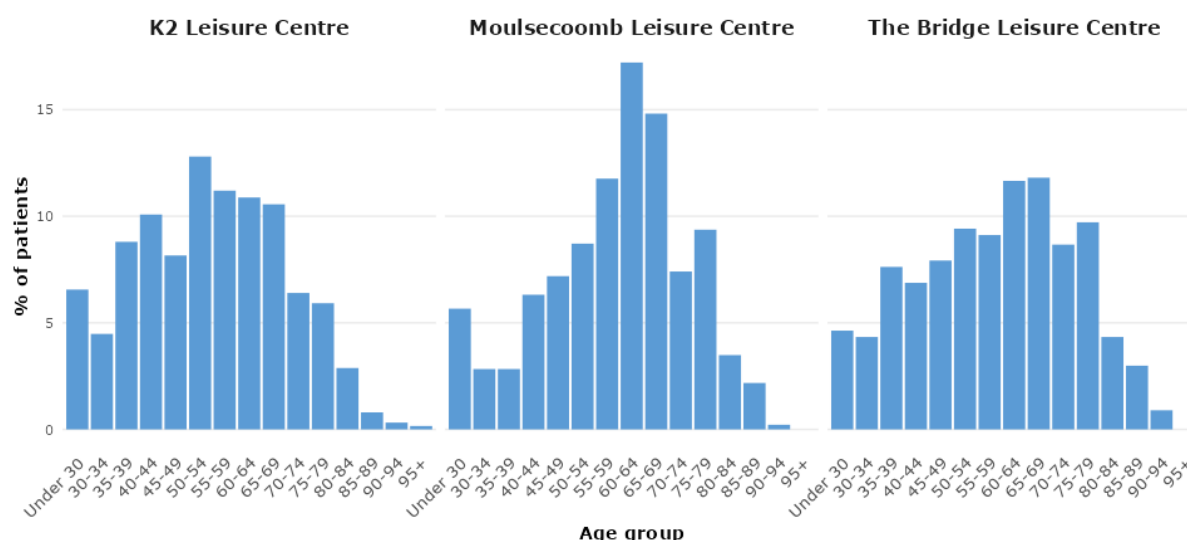


Figure 8: Proportion of patients invited to CAD services by site and age quintile

Gender

Overall, females made up the majority of invited patients (62.7% vs 37.4% male). The gender split of invited patients was consistent across the three CAD sites (see figure 9). Just one invited patient was reported with an 'unknown' gender (U).

This is not reflective of the gender distribution in these areas; approximately 50% of the population over 30 years of age in Crawley is female, 51% in Horsham and 51% in Brighton. Thus females are overrepresented in the CAD cohort compared to local population makeup. However self-reported MSK conditions are more prevalent in females (20.9% vs 15.8% in males)¹⁴ which may be reflected in the gender difference seen in this cohort, although the degree of variation is larger than the national 5% difference in MSK condition prevalence seen nationally.

¹³ Office for National Statistics (2024), Local Health Profiles. Access: <https://explore-local-statistics.beta.ons.gov.uk/areas/E12000008-south-east>

¹⁴ Ipsos/NHS (2023). GP Patient Survey. Access: <https://www.gp-patient.co.uk/>



Figure 9: Proportion of patients invited to CAD services by site and gender

Ethnicity

Ethnicity data was poorly completed, with 66.6% of the records with 'NULL' recorded. Of the remaining 33.4% with an ethnicity recorded, 86.1% were recorded as White, 8.5% as Asian/Asian British, 2.4% as of Mixed ethnicity, 1.9% Black/Black British and 1.2% Other ethnicity.

This high degree of missingness makes breakdown across different sites difficult to interpret and impossible to judge the extent to which the ethnic profile of the patients invited to CAD events reflected the local population. The degree of missingness did vary between the sites; K2 reported 'NULL' ethnicity for 57% of the invitees, The Bridge reported 68% as 'NULL' and Moulsecoomb was the highest degree of missingness with 78% of the invited cohort with 'NULL' ethnicity recorded.

Given this poor data completeness, ethnicity has been excluded as a variable for analysis throughout the rest of these findings to help avoid misinterpretation and erroneous conclusions,

Deprivation

Overall, patients invited to the CAD events were from the least deprived end of the deprivation spectrum. 51.3% of invitees were from deprivation quintiles 4 or 5, 23.5% from quintile 3, and 25.2% from the most deprived quintiles 1 or 2, with 5.7% in quintile 1 and therefore part of the CORE20 group that forms part of the national focus for reducing health inequalities¹⁵.

There were significant differences in the distribution of deprivation across the cohorts for each CAD site; figure 10 extends the analysis to look at deprivation deciles (instead of quintiles) and the difference between the sites can be clearly seen. Invitees to the CADs held at the Bridge in Horsham are much more likely to be from areas of the lowest deprivation compared to the K2, Crawley cohort. Whilst the K2, Crawley cohort is not notably very deprived, with a small proportion in the 1st and 2nd, the distribution of patients across deprivation quintiles is

¹⁵ NHSEngland (2023), Core20Plus5- an approach to reducing health inequalities. Accessed: <https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/>

skewed towards the 4th-6th deciles compared to the clear dichotomy evident in Horsham with relatively high proportions of invitees resident the 6th decile and the 10th decile.

This is keeping with the general deprivation profiles of the two areas; Horsham is typically characterised by higher socioeconomic indicators, lower deprivation levels, and a more affluent demographic profile compared to Crawley. Crawley, while economically diverse and with a significant industrial base, faces higher levels of deprivation across several key indicators.

The deprivation profile for Moulsecoomb, Brighton CAD events is different again, with a much more even distribution across all deprivation deciles. Again, this is indicative of the general deprivation profile for the area which is complex and varied due to a wide range of factors such a diverse housing portfolio and employment opportunities.

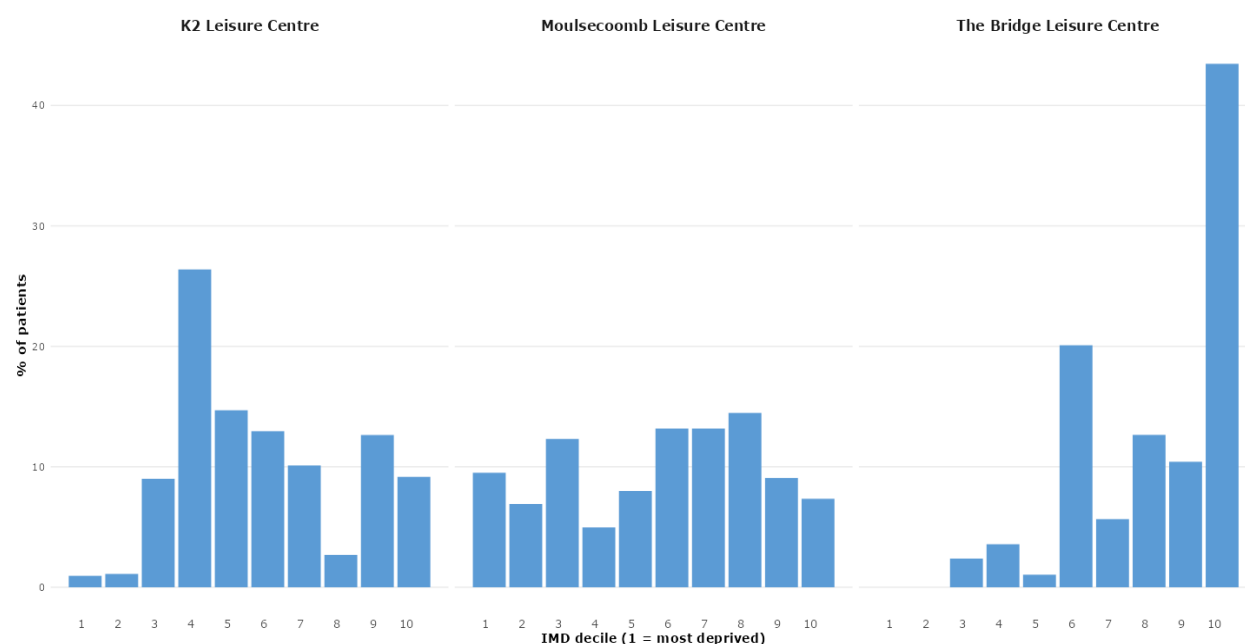


Figure 10: Proportion of patients invited to CAD services by site and IMD decile

Reasons for coming (primary complaint)

Patients invited to CAD events had a range of primary complaints for which they were referred. The main primary complaints, accounting for 55% of all patients invited were related to hip joints, knee joints and back pain (see figure 11).

A relatively large proportion of records did not record or stated ‘unknown’ reason for CAD attendance (23%).

The primary reasons for attendance were similar between the Crawley and Horsham CADs. However, the Moulsecoomb CAD reasons for attendance were almost entirely in relation to

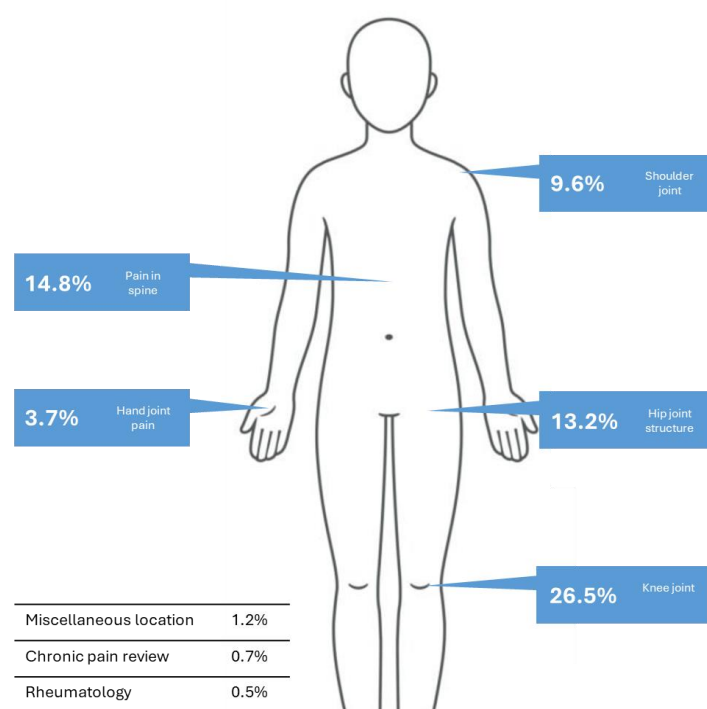


Figure 11: Proportion of patients invited to CAD services by primary complaint

hip joints and knee joints, reflecting the narrower focus for the CAD held at Moulsecoomb that differs from the other two CAD sites and may have impacted on the demographics (see above) of those invited.

The activity data provided did not allow for identification of whether attending patients presented with any issues in addition to their primary complaint. However, feedback from the patient survey and interviews (see pages 14 to 31) suggest that a number of patients consulted on multiple complaints and in fact saw this as an advantage of attending the CAD.

Attendances, DNAs and cancellations

Of the individuals invited, the vast majority attended the CAD; 17.4% of invitees (n=307) did not attend. Of these, 43% cancelled their

appointment in advance, 8% had their appointment cancelled by the service, and 49% did not attend (DNA) on the day.

There was a notable difference in this pattern between sites. Table 4 shows the proportion of invited patients for each site that attended the CAD (even if they did not finish the session), cancelled their appointment, or DNA. The proportion of DNAs evident at the Crawley site was much higher than the other sites. The relatively higher proportion of patient-initiated cancellations at Horsham was not large enough to offset the overall difference in attendance rates compared to Crawley. The more focussed nature of the Brighton CADs may have been a factor in the high attendance rate.

Table 4: Attendance, DNA and cancellation rates for each CAD site

Site	Attended	Cancelled by patient	Cancelled by service	DNA
K2, Crawley	79.47%	6.79%	2.05%	11.69%
The Bridge, Horsham	83.63%	8.48%	1.79%	6.10%
Moulsecoomb, Brighton	85.53%	6.91%	0.22%	7.34%

The demographic characteristics associated with DNAs (did not attend) and cancellations may provide some understanding of the reasons why patients chose not to attend. In general, females were more likely to have a DNA (9.04%) than males (7.40%) and were more likely to cancel the appointment in advance (8.50% in females, 5.74% in males). There does not appear to be any significant impact of deprivation on the likelihood of either DNA or patient-initiated cancellation; the distribution is evenly dispersed across all IMD deciles. However, age does appear to be a factor, in both DNAs and patient-initiated cancellations. Of those patients that DNA, 84% were under 65 (see figure 12, top chart), potentially reflecting the challenges of same-day attendance for those of working age. Patient initiated cancellation exhibited a markedly different pattern, with more than half of cancellations from patients between 45-65 years of age (see figure 12, lower chart).

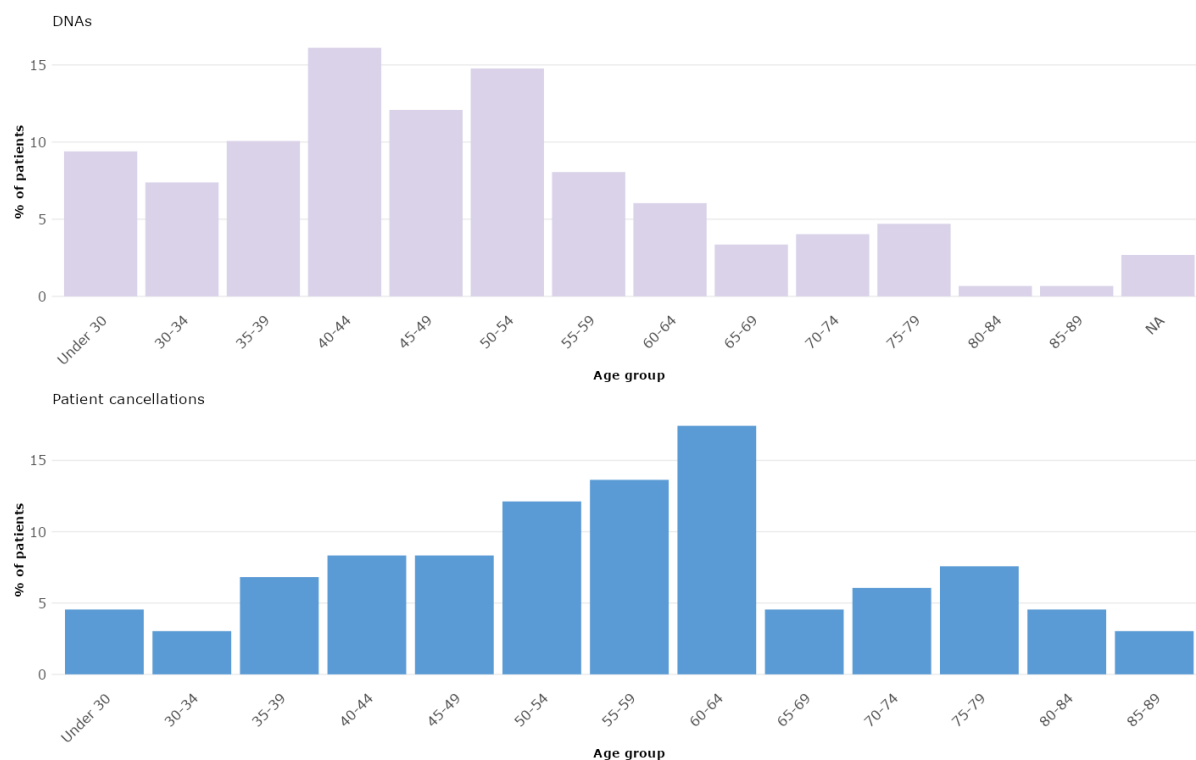


Figure 12: DNAs (top chart) and patient initiated cancellations (lower chart) by age group

Outcomes

The outcomes of the CAD appointments for patients with a 'finished' appointment status were recorded in 96% of cases. Overall, 52% of patients who completed the CAD event were discharged, the vast majority (95%) with the option of patient initiated follow up (PIFU).

Of those not discharged, with or without PIFU, 18.4% had their care transferred to another clinical team, 18.4% were referred to the Integrated Clinical Assessment and Treatment Service (ICATS). The majority, 53.9%, were recorded as 'follow up'.

There were some differences in outcome of CAD appointments between sites, largely driven by the focussed nature of the Moulsecoomb, Brighton events. These events had a much higher proportion of patients (28.9%) being transferred to other clinical teams, presumably consultant-led services for surgical or other intervention for hip and knee issues, compared to the other sites (less than 2% in both cases). The Crawley and Horsham CADs had similar patterns of outcomes, with no significant difference in terms of proportions. All three sites had 'discharge with PIFU' as the most common outcome, accounting for 51.9% in Crawley events, 50.4% in Horsham events and 44.0% in Brighton.

Reviewing outcomes by age group did not show any significant differences, with distribution of each possible outcome fairly evenly distributed across all age groups. Similarly, there was no significant differences between the genders in terms of outcome; outcomes for both males and females reflected the overall proportions.

There was however some evidence that outcome did vary by deprivation level (see figure 13). Patients who were in lower, more deprived, deciles were more likely to have a 'follow up' outcome and also more likely be transferred to another care provider. This is also reflected in the 'discharge with PIFU' outcome where, in general, higher, less deprived, deciles were more likely to be discharged. The correlation between deprivation decile and proportion of patients with a 'discharged with PIFU' outcome shows a moderate relationship ($R^2 = 0.53$), where decreasing deprivation is related to increasing rate of PIFU.

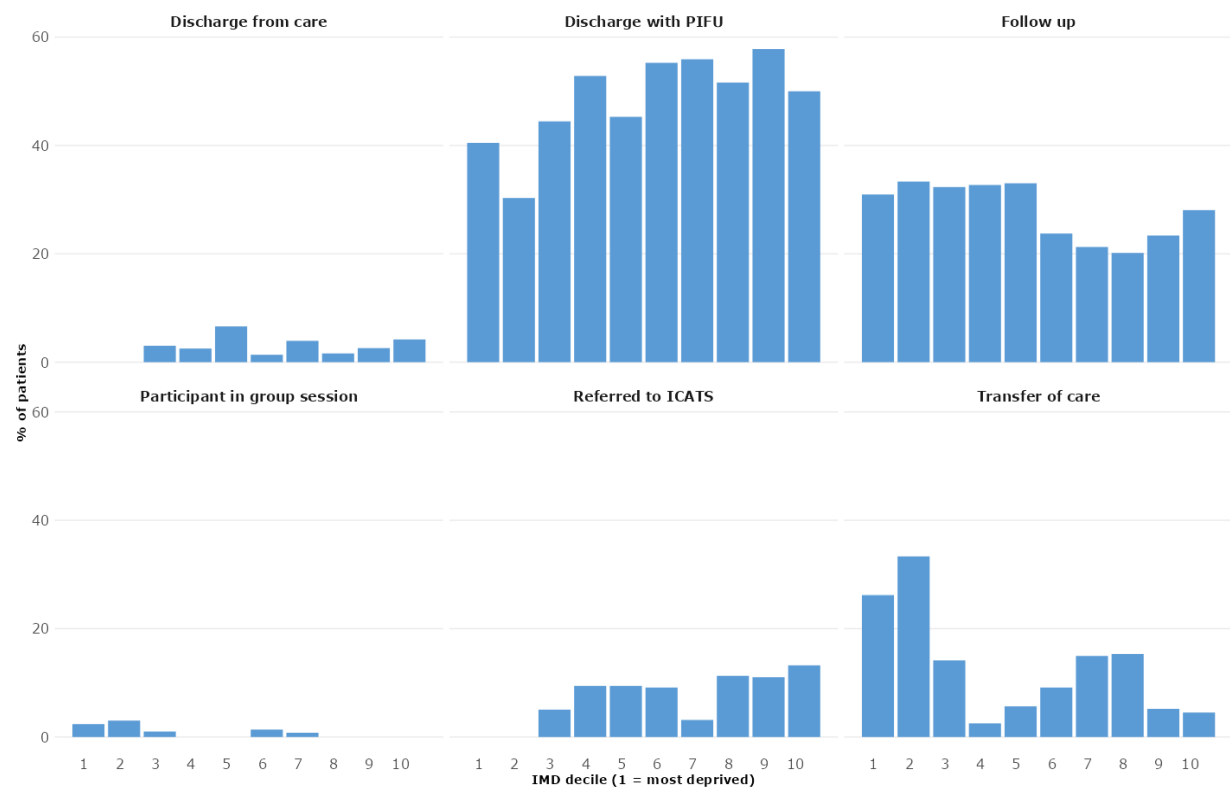


Figure 13: CAD appointment outcomes for patients who finished their appointment, by IMD decile

Attendances at CAD areas

In all CAD events there were four core clinical areas:

- What matters to you
- Let's assess together
- Rehabilitation
- Advice and guidance

Other clinical areas were available but may have varied between CAD events depending on availability of clinical teams and focus of the event.

Nearly all CAD participants attended a 'What matters to you' (WMTY) session, although there was some variation between sites; in K2, Crawley 96% of attendees were recorded as going to a WMTY session and, compare with 91% in The Bridge, Horsham.

The pattern of attendance at each of the clinical areas is similar in both the Crawley and Horsham sites (see figure 14). After WMTY, rehabilitation was the most commonly attended clinical area, with the proportion of patients attending at the remaining and 'other' clinical services fairly evenly distributed. This pattern varied in the Brighton site, with 'Let's Assess Together' and Other clinical services with a much higher attendance proportionally compared to the other two sites. This is likely linked to the more specialist focus of the Brighton CADs and may reflect alternative care required for this cohort, which may, for example, require more surgical input.

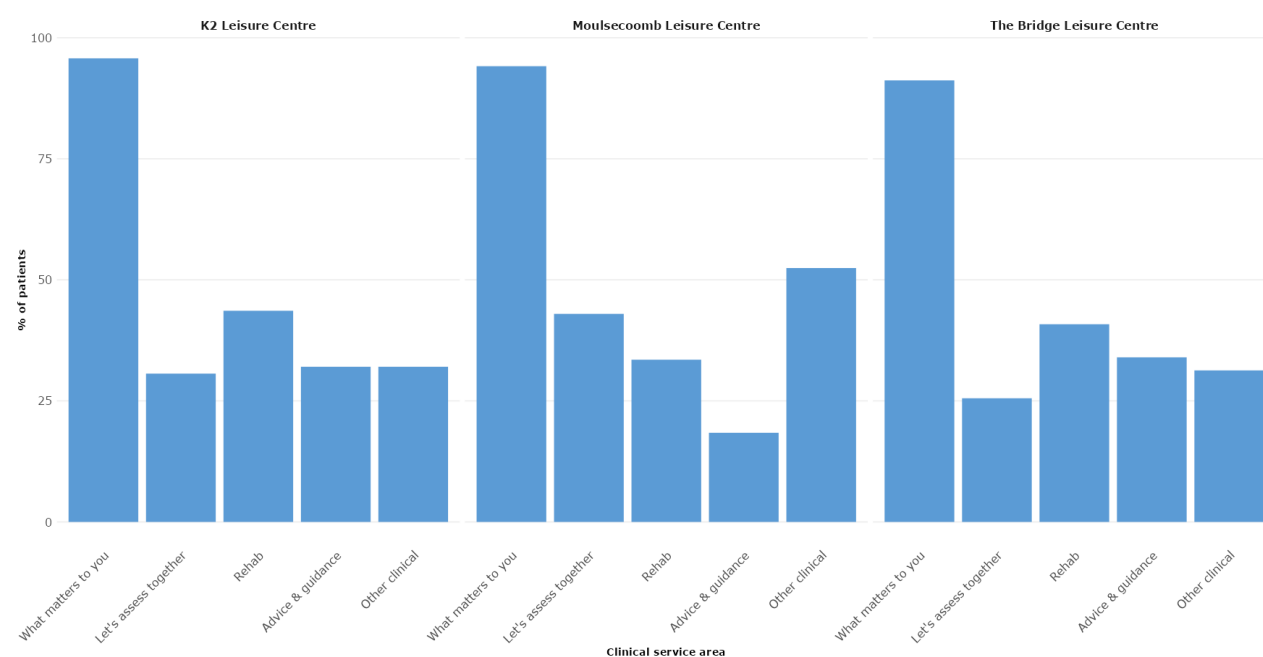


Figure 14: Proportion of attending patients at each CAD clinical area by site

Analysis of attendance at each clinical area by key demographic factors (gender, age group and deprivation) do not reveal any significant differences between groups. This supports the hypothesis that the CAD clinical areas are responsive to needs across all groups.

An examination of clinical area attendance figures by key demographic factors, such as gender, age group, and deprivation, does not disclose any significant disparities between groups. This finding corroborates the hypothesis that the clinical areas in question are responsive to the requirements of all demographic groups.

The frequency of attendance at the community hub, and the utilisation of non-clinical support services within the CADs, was significantly lower compared to clinical services. The specific services represented within the CADs exhibited variability, precluding direct comparisons across different locations and demographic groups. This variability is evident when examining the individual services that were most frequently attended. In the Crawley CAD, West Sussex talking therapies, weight management, and falls services had the highest number of attendees, with 15, 10, and 9 individuals, respectively. In Horsham, the pedometer service was the most frequently attended, followed by the health hub and women's health (north), with 79, 12, and 10 attendees, respectively. In Brighton, 13 attendees were recorded as visiting the community hub, with no other specific services having any recorded attendances.

Waiting list impact

Whilst the primary aim of the CAD initiative was not to seek to reduce waiting lists, this has been noted as a potential side effect of inviting and seeing a significant number of patients in one go, the majority of whom are discharged to a self-management pathway.

The data of community waiting times, subjected to statistical process control analysis, demonstrates a different pattern in waiting list volume compared to that of England as a whole (see figure 15). The top chart in this figure shows a stable waiting list volume for Sussex MSK Partnership from January 2023, dropping in April and May of the same year but not so much as to suggest statistically significant improvement. This control is maintained up to February 2024, followed by a series of months with growth in the list to a point which may indicate statistically significant increase in the list size.

This compares favourably to the overall England trend, which increased throughout nearly all of 2023. A period of reduction between November and February is also followed by a period of increase and a shift back to volumes statistically significantly higher than may be expected.

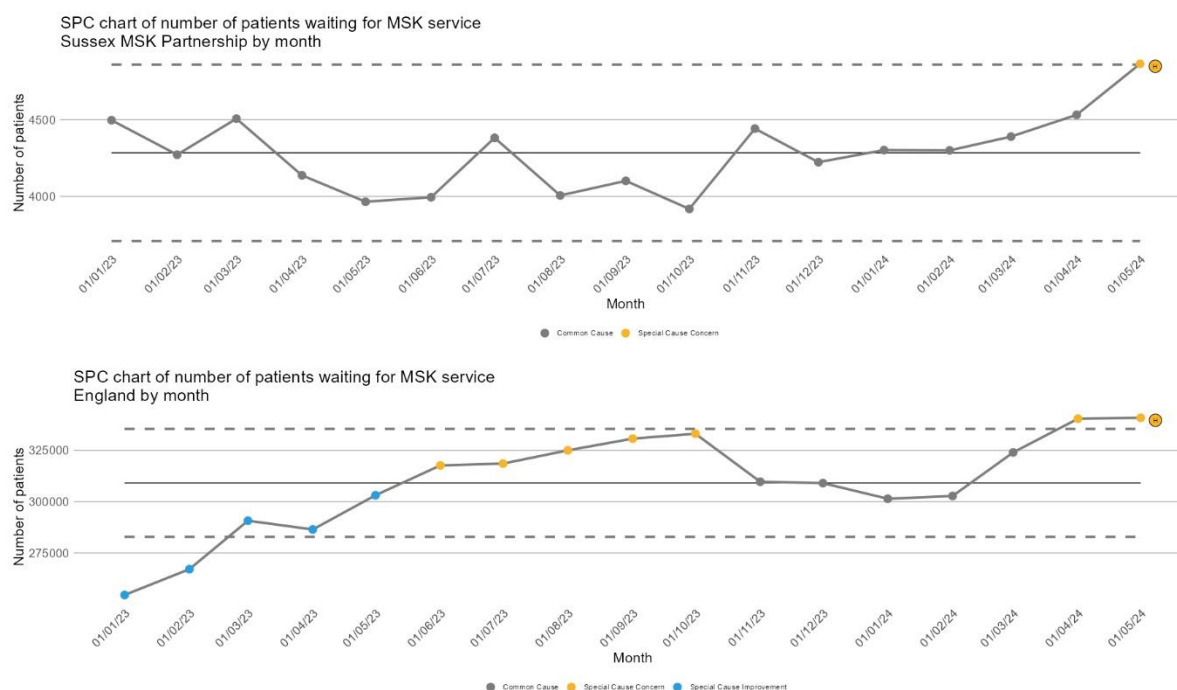


Figure 15: SPC chart of waiting list volume by month for Sussex MSK Partnership (top chart) and England (lower chart)

The size of the waiting list for community MSK services is just one measure of the potential impact of the CAD initiative. Given that the final CAD included in this analysis was run in December 2023, and demand for community MSK services continue to grow, it is perhaps not surprising that the volume of people waiting for these services in the Sussex MSK Partnership catchment area has risen. Perhaps a better measure is an indication of how long people are having to stay on the waiting list. Using 18 weeks as a (fairly arbitrary) performance cut off, it is clear that Sussex MSK Partnership has managed to drive the number of people experiencing longer waits down, below a statistically significant level, and keep them low and stable for a sustained period of time (see figure 16), despite growing demand. This compares favourably to the overall England picture where the numbers of people waiting more than 18 weeks for community MSK services has continued to rise well above statistically significant levels.

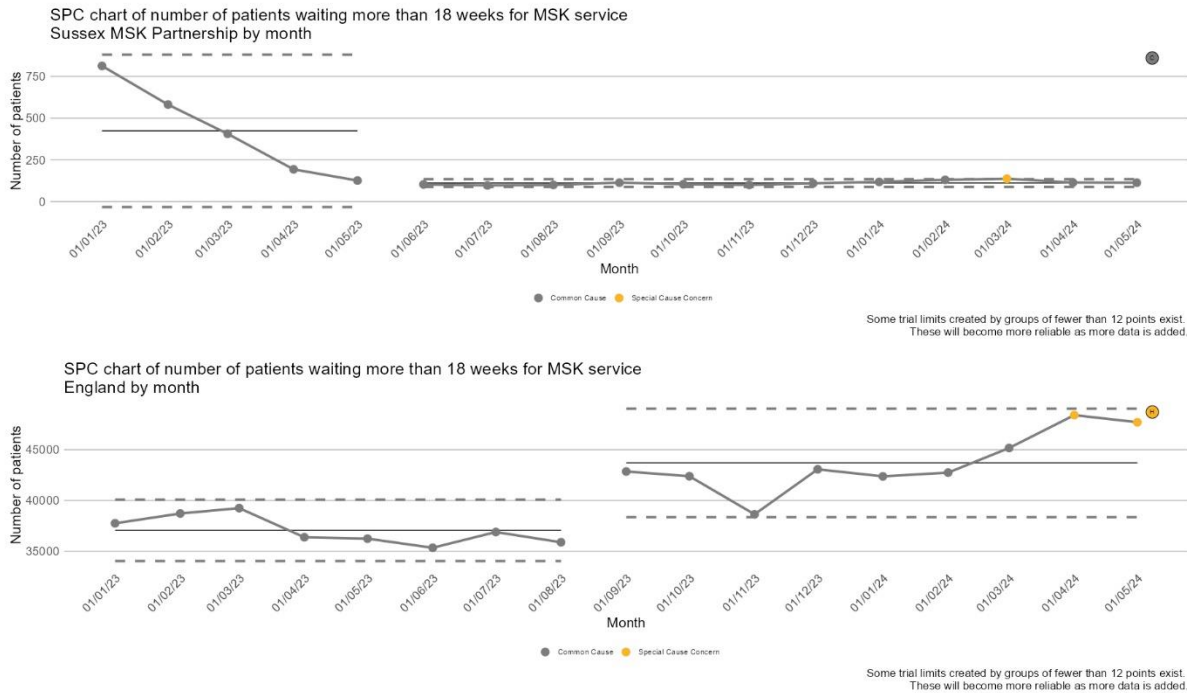


Figure 16: SPC chart of numbers of people waiting more than 18 weeks by month for Sussex MSK Partnership (top chart) and England (lower chart)

Neither of these community MSK waiting list measures are granular enough to provide clear evidence of a causal link between the CAD initiative and lowering of waiting list volume and waiting times beyond a correlation of implementation dates and the known high volume of CAD attendees discharged from the list for self-management. More detailed longitudinal analysis of longer-term outcomes, including PIFU take up would be required to build a more comprehensive picture.

Nevertheless, the theory of change behind the CAD initiative is suggestive of impact on waiting lists and is additionally supported by the qualitative findings outlined above and the stark difference between the trend in volume and time waiting for Sussex MSK Partnership compared to England as a whole.

Discussion

Interpretation of findings against KEQs

In this section, the findings from all the data sources outlined above are synthesised to provide insight into the key evaluation questions outlined at the beginning of the report. By triangulating data sources, we ensure a robust evaluation that accounts for as many perspectives as possible. This synthesis aims to deliver clear, evidence-based conclusions about the CAD initiative's overall effectiveness and highlights areas for potential improvement and further research required.

Does CAD have an impact on future service utilisation for those people that have attended?

The primary focus of the CAD initiative is to ensure that attendees have the support they need to self-manage their conditions where they can, and the expert insight they require to identify their 'next step' should further treatment be required. Before the implementation of CAD the pathway for usual care would have been a single, probably physiotherapist led, assessment appointment with onward referral for rehabilitation or other clinical service or discharge to GP. Data that described this original pathway in quantitative terms was not available at the time of writing.

The finding that more than half of CAD attendees are discharged to self-management, with option to initiate follow up in the majority of cases (so would therefore not be re-added to the waiting list), suggests that the longer term service utilisation for those that have attended is likely to be impacted.

Firstly, instead of 2 or more appointments to reach a point of discharge, from the patient perspective, just one appointment is needed. From a system resource point of view this is hard to compare to usual care; the numbers of staff required to deliver a CAD, typically around 300 people, may have been the number of staff required to deliver all the required appointments in the original pathway. Internal estimates from Sussex MSK Partnership suggest that the CAD was able to see three time more new patients with the same resources compared to usual care, although this could not be formally verified using the data available for this review. However, the speed with which such a large volume of patients could be suggested to impact on clinics further downstream, either reducing demand or enabling longer consultations.

Secondly, the high proportion of discharge to self-management, coupled with qualitative and survey feedback from patients that they feel confident in the new skills and information they have acquired at the CAD, suggests that with the right tools, patients are less likely to require additional follow-up, at least in the short term. This is supported, again by internal data from Sussex MSK Partnership, by the reduction in first to follow up ratio from 2.3 follow ups to each first appointment, to just 0.6 follow ups to each first appointment. This could not be formally verified using the data available for this review and it is not clear if this is a general reduction in follow up ratio or just applicable to areas where a CAD was held.

Aggregate data from Sussex MSK Partnership allowed a high-level comparison of PIFU as an outcome at first appointment for new patients attending the CAD versus those in other Sussex MSK Partnership services. As anticipated, this shows a much higher PIFU rate for CAD patients (>50%) compared with just 12% in other 'traditional' services. The PIFU *return* rate for traditional services is around 10% (although this may be for either first or follow up patients, so is not exact) and for CAD patients is higher at 23%. Given that the PIFU outcome is four times higher in CAD patients, and therefore is presumably impacting a much wider group of

patients, the higher rate of 23% is arguably much lower than may be expected. This suggests that the CAD does have a positive affect on the longer term self-management. It may be expected that, if the PIFU uptake resulting from the CAD initiative remains relatively low, and there is no deterioration in patient outcomes, that it could be concluded that the initiative will reduce demand on future service utilisation, at least for Sussex MSK Partnership services.

It should however be noted that, more generally, the evidence base around PIFU, and its effectiveness as a mechanism for encouraging self-care whilst safety-netting patients who may be in need, is poor.

The data required to understand whether the CAD initiative impacted on service utilisation *more generally* was not available. Ideally a longitudinal approach would be employed, linking CAD attendees' data across Sussex MSK Partnership, GP and secondary care records in order to build a picture of their service use before and after the CAD. Comparing this utilisation to a group of patients who didn't or were not invited to attend, would provide clear evidence of what type of service utilisation has been impacted, and to what extent. It could be hypothesised that some services may be more impacted than others (e.g other physiotherapy services may see more of an impact of CAD on demand than on GP services), and an understanding of this would support a holistic view of the impact of the CAD at a system and whole pathway level.

Taken together, the evidence presented does support a positive impact in terms of reducing the onward service utilisation of patients who attend the CAD, driven by improved self-management. However, the evidence presented here is indicative at this time and further analysis of longer term PIFU take up by those who attended, and a comparative piece of work that can assess the difference in service utilisation across the system would be required to provide the necessary detail for final conclusions.

How do patients experience CAD?

The direct feedback from patients through survey feedback and short interviews demonstrates that their experience was almost universally positive. In particular, the strong scoring on the Collaborate questionnaire is an endorsement of one of the CAD's primary goals which was to ensure that it '*supports our population and enables them to take an active part in their care AND support them with what matters most to them*'. Patients overwhelmingly felt that they were involved in their care, listened to and what mattered to them was included in the care and advice they were provided. The staff at the CAD also felt that this key goal was met either very or extremely well. This reflection, from a different perspective, reinforces the positive experience of patients.

The goal noted previously is pre-fixed with '*doing things differently*' and this was also remarked by patients, who on some occasions noted the CAD as being novel and different approach compared to usual care. This comparison to their previous care or care on other services, was generally complimentary to the CAD experience.

Of particular note was the positive sentiment related to advice and guidance received. This spoke to the importance of the reassurance of having face to face contact with an expert, relevant to the individuals' context. Whilst what was advised (for example specific exercises) could have been given via a remote appointment, or a patient information leaflet, the demonstration of exercises and personalised discussion available in the CAD environment could have led to the high degree of satisfaction and confidence exhibited in the survey and interview feedback.

Where feedback from patients was not so positive this was often related to operational concerns with regard to waiting and directions, and specific individual needs that had not been

explicitly taken into account. The format of the CAD, in a large and inevitably busy space, was not suited to all attendees, and improvements in preparing attendees for what to expect was a key theme. However, in general, negative sentiment was often accompanied by positive reflections.

Overall the evidence available with regard to the patient experience of the CAD suggests that patients engaged well with the format, enjoyed it and found personal benefit. There is little question that the key goal of enabling people to take an active part in their care and support with what matters most for them has been met from the perspective of CAD attendees.

How do staff experience CAD?

The staff who came together to deliver the CAD events were from a wide range of professional backgrounds and broadly enjoyed the event and found it personally beneficial. The evidence from the staff survey, acknowledging that it only related to two of the six CAD events held, was almost unanimously supportive of the concept and felt that the approach offered value for the patients who attended and added to their own professional experience.

Primary amongst the positive sentiments was the ability to spend quality time with patients, getting to know what mattered to them and providing advice, treatment or onward referral in partnership. The value the format added to the patient was a key aspect of the enjoyment of the CAD experience for staff. In addition to this, the atmosphere and close working with colleagues who otherwise they would have little contact with was also a critical factor. The breaking down of professional and geographical boundaries fostered a sense of collegiality and shared purpose. This was noted by some patients as well in the patient survey and interviews.

Negative sentiment was largely operational in nature, with a focus on capacity pinch points, workflow and ensuring adequate rest breaks, and IT issues. The primary negative sentiment revolved around not having adequate preparation for what to expect in advance, a sentiment echoed by patients from their perspective. Some of this may have been related to the novel nature of the early CADs and would naturally become less of an issue over time for experienced staff. There was also evidence that 'on the day' feedback from the first CAD led to changes and adaptations for the second day, suggesting a positive learning culture.

There is ample evidence that the goal of the CAD to provide "*an opportunity to step out of your normal day, be supported by each other and work together whilst having sight of what is available in the community to support beyond just an MSK problem*" was met. It is clear from the limited feedback received from staff that they experienced the CAD positively; the argument for the benefits of such an approach in terms of 'hearts and minds' has clearly been won. However future CAD events will benefit from reflection on staff feedback and adaptation of the preparation and operational details of the day in response to this.

How well is CAD adopted/attended?

The overall conversion from invitation to attendance at the CAD was very high suggesting good adoption across all areas. It would be worth more investigation into the geographical differences in attendance rates to better understand whether any adaptations could be made in the Crawley location to encourage attendance, although its role as an early adopter site may have had an impact.

The lack of variation in attendance rate by deprivation and gender is reassuring, but the marked impact of age group on DNA rate, and the fact that patient-initiated cancellations are more likely to come from older, but still working age, invitees suggests that more could be

done to enable access for those of working age. A small number of patients in the feedback noted that they would have liked to have spent more time at the CAD but had to get 'back to work'. This was not prevalent enough to become a theme but provides some illustration of the difficulties inherent for some patient groups of allowing a relatively large amount of time on a working day. The fact younger age groups were more likely to DNA rather than cancel could indicate a *desire* to attend, but ultimately being unable to on the day.

In addition to this, consideration may be given to the emergent theme from the patient survey and interviews with regard to advance information and preparation. It is possible that not entirely understanding the purpose of CAD and the opportunity it affords them, may have influenced invitees with competing priorities not to prioritise their MSK concern.

In summary, the uptake of the CAD offer was very high and consistently so over the six events. Reflection on accessibility for working age groups may further improve uptake of the CAD and improving advance information could influence those with competing priorities to attend.

However, the analysis undertaken here is relatively limited. Further analysis of other demographic factors such as language spoken and disability, as well as improving the ethnicity data available, could also provide additional insight into potential variation in and barriers to participation. Follow up with individuals invited to but who chose not to attend the CAD may provide insight into personal preferences or challenges that may influence the decision to attend the CAD.

Are people who attend CAD able to explore broader issues that may impact their health and wellbeing?

Evidence from patient and staff feedback suggests that CAD attendees had been able to explore management and treatment of their MSK condition in the context of their own experience and situation. The almost universal attendance at the 'What Matters to You' clinical area and the key emergent theme of patients feeling listened to, coupled with the positive results from the Collaborate Questionnaire combine to suggest that the exploration of broader, personal issues that might impact their *MSK condition* was well supported.

In addition, a number of attendees noted that they were able to discuss more than one MSK condition or concern as part of their CAD, which also supports the provision of a service that takes broader issues into account.

However, the evidence for CAD attendees being able to explore broader issues that may impact their more *general* health and wellbeing was less clear. Attendance at the community hub, where more general health and wellbeing support was offered, had very low reported levels and was focussed on a small number of services. At the very least, if the low levels of attendance are a reflection of poor data quality rather than reality, the quantitative evidence is not currently available to support the use of the wider health and wellbeing offer at the CAD.

Individual pieces of feedback were positive about the availability of health and wellbeing interventions being available at the CAD, particularly blood pressure and diabetes checks and other lifestyle interventions and advice. The fact that the volume of feedback of this type was low, coupled with individual items of staff feedback from specific CAD events that the community hub was 'out of the way' or 'poorly attended by community groups' suggests that there may be operational improvements in patient flow and engagement with community health and wellbeing groups that could be made to encourage greater use of the wider services on offer.

Overall, in the context of the presenting, and occasionally other, MSK conditions, the CAD was successful in ensuring patients had the time and opportunity to really explore the wider issues impacting their MSK condition(s) in their own context. Further improvement could be made from the perspective of even greater holistic care by thinking about how to improve the attendance at and breadth of representation of wider health and wellbeing services.

How does CAD impact inequity?

The data analysed throughout this report has sought to breakdown all the factors examined by as many demographic factors as possible to obtain some insight into whether any disparities are present in the delivery of the CAD initiative.

Whilst analysis by ethnicity was not possible due to poor data quality, the dimension of age, gender and deprivation could be analysed in relation to the activity data provided. It was generally not possible to understand whether patient experience varied by these dimensions as the data provided was not linked to respondents' demographic characteristics.

The invitees and attendees at the CAD were broadly reflective of the communities in which the CAD events were held in terms of age, gender and deprivation. Small differences in the ability to attend, as understood through DNA and cancellation rates, between levels of deprivation and genders were not felt to be significant in statistical terms. However there was a clear impact of age on the ability to attend the CAD event, with significantly higher likelihood of DNA or cancellation in working age adults. Whilst MSK conditions are often associated with older adults, the average age of the CAD event invitees was 56 years of age, well within the working age range. In addition, it could be hypothesised that younger adults are likely to provide a greater opportunity for preventive care and thus benefit even more from the CAD model than older adults. In a similar vein, the wider economic impact of managing MSK conditions in working age adults in the form of reducing sickness absence could be an additional incentive to consider ways to improve access opportunities for this group.

There were also some differences in outcomes evident from the perspective of deprivation, where CAD attendees from more deprived areas were more likely to be referred for follow-up or transferred to another service, compared to those in less deprived areas who were more likely to be discharged to PIFU. The apparent relationship between decreasing deprivation and increasing rates of PIFU could be caused by any number of factors and does not indicate causality; however, deprivation is associated with greater health need and this pattern may indicate that patients with a higher degree of deprivation are appropriately being referred to the additional follow up care to meet that need.

Whilst the patient surveys were generally not possible to breakdown by key characteristics, the noted trend in 'being listened to' being a predominantly female theme is possible evidence that the CAD could reduce inequity. Women often feel that their concerns are not listened to in healthcare settings, which has been attributed to limited consultation time in some studies¹⁶. The disproportionate number of women citing having their voices heard as a benefit of attending the CAD is potential evidence this inequity is addressed through the CAD model.

Overall, there is certainly no evidence in the analysis undertaken here to show that the CAD initiative has in any way perpetuated inequalities and some evidence that it may be reducing them. There are however clear indications that access could be improved, particularly for working age adults.

Limitations

¹⁶ Department of Health and Social Care (2022) *Women's Health Strategy for England*. Accessed: <https://www.gov.uk/government/publications/womens-health-strategy-for-england>

Please note that this is an interim report and that, as such, findings and interpretations are based on a relatively small amount of data across just six events (two of which were selective in terms of MSK conditions attending) and should be viewed with the requisite caution.

This was not a formal, independent study and as such the data sources used may contain bias. There is also no comparator or control group included in the analysis and as such it is not possible to say whether the CAD initiative as an approach to MSK care delivery is better or worse than other models of 'usual' care.

There are some significant gaps in analysis which could strengthen the answers to the key evaluation questions:

- No longitudinal data on previous and subsequent service usage within and outside of Sussex MSK Partnership Services: having this would enable greater insight into behaviour change with regard to use of services before and after the CAD intervention and help assess the evidence of whether the CAD initiative makes a difference at the system level. It would also likely form the basis of a robust health economic analysis.
- Time waiting and movement between stations within the CAD: this was not available in the current dataset but could provide the quantitative insight that builds on the qualitative feedback, to understand where key capacity pinch points occurred and could provide insight into how patient flow and staff distribution could be improved.
- Poor data quality for attendance and services visited in the community hub: the relatively poor data quality with regard to the community hub leads to an incomplete picture of the holistic input that patients chose to engage with, and a lack of quantitative evidence in terms of which services could be built in as 'standard' for future CADs.
- No understanding of the demographics of individual patient replies in the patient survey: whilst this data may be available, for reasons of governance it was not included in this analysis. A breakdown of some of the key themes emerging by age group and ethnicity may have provided additional insight into the patient experience of the CAD
- Lack of PIFU uptake rates following CAD: internal analysis of PIFU rates from Sussex MSK Partnership between CAD and 'traditional' services have been included in discussion here. However, detailed data on which patients initiated PIFU and when was not available for this analysis. Understanding how patients discharged on a PIFU pathway then utilise their ability to initiate follow up, stratified by key demographic factors and geography, is a critical piece of information in being able to form a view with regard to the impact of CAD on subsequent service utilisation and health inequity.
- Patient interviews were not without bias: the ad-hoc, informal design of the patient interviews were at risk of leading answers from interviewees. This was reflected in the almost entirely positive sentiment from this source.

Conclusions and recommendations

Based on the evidence presented in this report there is clear evidence that the CAD initiative has delivered on its core goals of supporting people with MSK conditions to confidently self-manage and provide staff with a novel and supportive environment in which to spend quality time with patients and each other. It is less certain how the CAD initiative has helped to realise health system benefit in terms of reduction in unnecessary service utilisation, although the impact on waiting list volume and length of wait appears to be clear.

In any case, the overwhelmingly positive sentiment from patients and staff suggests good acceptability of a new way of both engaging with, and working in, an MSK service. Where there was negative sentiment, the focus was on operational issues, where the opportunity to improve and fix such problems is well within the control of Sussex MSK Partnership. In short,

any battle for 'hearts and minds' appears to be won, but there is scope for continuous improvement in the on-the-day design and operation of a CAD event.

These positive conclusions could be further supported by widening the data available for analysis, and consideration of an independent data collection exercise, particularly of qualitative data. It is recommended, to enhance future evaluation and strengthen this existing review, that:

- Commission an independent qualitative data collection to add to the existing data on staff and patient experience and follow-up with non-attendees
- Consider linking CAD attendee data to primary and secondary care records to assess service utilisation pre- and post CAD attendance
- Refine the current data available on PIFU; research the utilisation of PIFU by CAD attendees, stratified by key demographics and analyse follow-up initiation reasons.
- Maintain a record of the review & learning activities in relation to the CAD initiative and what operational improvements are made in relation to these discussions

Appendix A: Patient survey questions

Section	Question	Detail
Collaborate Questionnaire	How much effort was made to help you understand your health issues?	Score: 1- 4 where 4 is more desirable
	How much effort was made to listen to the things that matter most to you about your health issues?	Score: 1- 4 where 4 is more desirable
	How much effort was made to include what matters most to you in choosing what to do next?	Score: 1- 4 where 4 is more desirable
General feedback	What did you like?	Free text
	Which area did you find most useful?	Free text
	What would you change?	Free text
	Any other comments or suggestions?	Free text

Appendix B: Staff survey questions

Section	Question	Detail
Respondent information	Which event are you leaving feedback for?	Select from list
	Are you in a clinical or non-clinical role?	Select from list and provide job title (free text)
	What area did you work in on the day?	Select from list with 'other, please specify' option
CAD specific feedback	How well did you think the day was organised?	5 point likert (Extremely well - Not at all well) with free text comment option
	Did you feel supported during the day?	5 point likert (Extremely supported - Not at all supported) with free text comment option
	One of the purposes for the day was "To do things differently that supports our population and enable them to take an active part in their care AND support them with what matters most to them." How well do you think we met this	5 point likert (Extremely well - Not at all well) with free text comment option
	One of the purposes for the day was "An opportunity to step out of your normal day, be supported by each other and work together whilst having sight of what is available in the community to support beyond just an MSK problem." How well do you think we met this?	5 point likert (Extremely well - Not at all well) with free text comment option

Section	Question	Detail
	What did you like best about the event?	Free text
	What would you have changed?	Free text
	Any other comments:	Free text