Exclusions – Brighton and Hove, Crawley and Horsham and Mid Sussex CCGs Outline Service Specification Final Version December 2013:

Patients with the following conditions will be excluded from the Service:

- Immediate life threatening conditions;
- Suspected cancers/2 week wait rule;
- Acute trauma, e.g. RTA or falls from a significant height, still in the acute phase;
- Patient with red flag symptoms, e.g. cauda equina, systemically unwell, significant weight loss, suggestions of serious infection or malignancy;
- Widespread neurology with or without upper motor neurone signs;
- Fracture Liaison services – There needs to be close relationships between both primary and secondary care with the MSK Service particularly with the relationship to the osteoporosis pathway.
- Chiropody
- Neurological, cardiorespiratory, amputee physiotherapy
- Falls service
- Complex hand surgery and rehabilitation where the procedure comes under Specialised Commissioning HRG
- Patients needing Emergency Department
- Headaches – except of cervicogenic origin
- Intermediate care services
- The Service does not include those services or treatments commissioned by NHS England under the heading of Specialised Commissioning
- Children (aged 16 and under)

SELF-CARE AND SELF-MANAGEMENT

Integrated MSK Service Website:

- Information on common MSK conditions
- Local condition-specific clinical pathways covering best practice assessment, diagnostics, management and outcome tools and referral thresholds
- Lifestyle choices and MSK wellbeing information
- Self-care advice, information, resources, tools, videos, Apps
- Sign-posting to local and national organisations and resources
- Secure messaging function to seek advice from MSK expert clinicians
- MSK Advice Line contact details
- Patient Decision Aids and shared decision making resources / tools
- Pre-Appointment Packs for patients who have been referred to the Integrated MSK Service

Nationally accredited structure self-care programmes provided by Arthritis Care and National Rheumatoid Arthritis Society (NRAS):

http://www.arthritiscare.org.uk/ and http://www.nras.org.uk/
http://www.heelfixkit.com
http://www.footcaresupplies.com/
http://www.simplyfeet.co.uk/
http://www.dreamyfeet.co.uk/
http://www.feetlife.co.uk/

- MSK Helplines – Arthritis Care 0808 8004050 and NRAS 0800 2987650
- MSK Condition Information Packs for newly diagnosed patients
- MSK Library of Conditions and Factsheets
- MSK Risk Calculator

- Tailored self-management programmes provided by Arthritis Care and NRAS including:
  - Chat for Change telephone education and support groups
  - Online Community Forum
  - NRAS and Expert Patient Programme Rheumatoid Arthritis Self-management Programme
  - Joint Approaches modular self-management workshops
  - Challenging Pain Programme
  - On-line self-management course
  - Arthritis Champions providing 1-2-1 and community support

Other self-care support:

- Integrated MSK Service Leaflet and information on common MSK conditions in local Pharmacies

- The Federation of Disabled People - **http://www.thefedonline.org.uk/** and telephone **01273 296747**
  - advice, information and support; sign-posting; social prescribing; Direct Payments and Personal Budgets support; peer support; Get Involved Group

- The Carers Centre - **http://www.thecarerscentre.org/** and telephone **01273 746222**
  - carers support packages i.e. Advice Phone Line; support, advocacy and information; Carer Support Groups

- Local Authority initiatives – i.e. Health Champions / Trainers, Alcohol Reduction Programmes, Exercise Referral Schemes, Weight Management, Social Services, Falls Prevention Service

- Action in Rural Sussex - **http://www.ruralsussex.org.uk/** and telephone **01273 473422**
  - provides sign-posting, advice and information

- Sport Development Team - **http://www.brighton-hove.gov.uk/content/leisure-and-libraries/sports-and-activity/sports-development** and telephone **01273 292724**
  - provides sports injury advice and information

Referral reason / Patient presentation	Primary Care Management	Thresholds for Primary Care to initiate a referral	Management Pathway for the Integrated MSK Service	Thresholds for referral to Hospital / In-patient care	Management pathway for Hospital / In-patient care
Plantar Fasciopathy / Heel pain *Soft tissue pain in heel / arch provisional diagnosis, Heel pain, plantar enthisopathy, plantar fasciitis*	**Investigation:** • History • Examination and Assessment • Exclude nerve root pain ***(see Spine guidelines for management & guidance)*** • Absence of neuro or vascular symptoms • Less than 6 week duration • Absence of single traumatic episode **Diagnostics:** • **<u>None</u>** **Management (including condition-specific self-care**	**Refer to Integrated MSK Service (Triaged to Extended Scope Practitioner) if:** • Failure to create sustained improvement within primary care management • Symptoms more than 6 weeks with significant functional impairment	**1 Patient education and information** **2 Assessment and Examination (Extended Scope Practitioner)** ○ Consideration of differential diagnosis ○ Neurovascular component **3 Investigations** Consideration of further tests: • X-ray traumatic - query fracture component • Ultrasound if bursitis or tenosynovitis	**N/A**	**N/A**

	options): • Patient education (http://www.heelfixkit.com/) • Assessment and advice regarding footwear - avoiding totally flat or high shoes • Calf muscle exercises / stretches • NSAIDs in line with agreed formularies / guidance • Simple analgesics e.g. paracetamol in line with agreed formularies / guidance • Activity restriction • 'Off the shelf' heel pad • **Do not inject** • Education re natural history, self-management for 6-9 months		• Nerve Conduction Studies - nerve entrapment • X-ray / MRI – Avascular Necrosis **4 Management (Podiatrist / Extended Scope Practitioner):** Stage 1 • Suspected spinal component - **treat as red flag** • Explanation with leaflet or diagrams as required • Specialised Footwear (self-purchased) and stretch advice • Home Exercise Program – HEP • Taping • Gait re-training • Orthoses to address mechanical issues • **Steroid Injection not advisable less than 3 months** • **Ultrasound guided injection** • Blood tests – if inflammatory component Stage 2 • Dry needling • TOPAZ procedure- day case Podiatric surgery • ESWT (Extracorporeal Shockwave Therapy) – IP6311 Nice Refractory fasciopathy- currently delivered at Montefiore and Goring Hall **Consider Spine pathway if:** • back component identified **Consider Rheumatology pathway if:**		

			• Suspected ankylosing spondylitis **4 Outcome Tools** • MOXFQ (The Manchester-Oxford Foot Questionnaire) • PASCOM (Podiatric Audit in Surgery and Clinical Outcome Measure) • EQ5D • SURE **Hub environment (could be spoke but 10 metre walk way required for all patients)**		
Referral reason / Patient presentation	**Primary Care Management**	**Thresholds for Primary Care to initiate a referral**	**Management Pathway for the Integrated MSK Service**	**Thresholds for referral to Hospital / In-patient care**	**Management pathway for Hospital / In-patient care**
Hallux Valgus / Bunions *Bony deformation of the first ray with lateral deviation of the great toe.* *May be asymptomatic, painful in preferred shoe gear, painful affecting walking or debilitating.* *The pain may be deep (bony) or superficial i.e. affecting the skin overlying the bony prominence.* *Lesser toe deformity may occur concurrently.*	**Investigation:** • History • Examination and Assessment • Exclude inflammatory disease • Assess preferred footwear **Diagnostics:** • **<u>None</u>** **Management (including condition-specific self-care options):** • Pain relief in line with agreed formularies / guidance • Patient education • Consider blood test if Rheumatoid element / inflammatory disease / sero-neg arthropathy / gout is likely • Accommodative footwear • Over the counter orthotics if flat foot	**Refer to Integrated MSK Service if (Triaged to Extended Scope Practitioner / Podiatric Surgeon / Orthopaedic Consultant):** • Persistent pain unable to manage through shoe change • Increasing deformity, especially with family history. • Pain elsewhere in the foot due to altered foot mechanics • Affecting ability to work • Affecting activities of daily living	**1 Patient education and information** **2 Assessment and Examination (Extended Scope Practitioner)** • Consideration of Causal Origin (genetic, biomechanical, inflammatory) **3 Investigation & diagnostics:** • Full blood count, ESR, CRP and uric acid required if systemic cause thought likely • Plain film x-ray if diagnostic uncertainty • Plain film x-ray (weight bearing AP and lateral) **<u>only if</u>**: • surgical opinion required to assist with planning • to identify Rheumatological component	**Offer patient choice of provider if patient needs and wants surgery and is fit for surgery** **If patient needs and wants surgery but is not fit for surgery, refer to GP for further management** Day Case / no direct listing	**1 Listed for surgery based on i.e.:** • Pain • Condition limiting function • Patient has been through stage 1 and 2 of the Integrated MSK Service and is confirmed as a surgical candidate **2. Surgical pathway:** • Patient fasted - food 4 hours prior to procedure, liquid 2 hours • IV Cannula sited • Sedation requirements • WHO surgical safety checklist completed **3. Discharge criteria:** • Neurological checks completed • Pain controlled • Mobile at pre-op level • Medically stable • Provided with appropriate post-operative exercises • Bunions- follow up at 6/52

			4 Management (Podiatrist / Extended Scope Practitioner / Podiatric Surgeon / Orthopaedic Consultant): • Explanation with leaflet or diagrams as required • Enhanced shoe wear advice <u>Stage 1:</u> • Patient education • Orthoses provision <u>Stage 2**:**</u> • NSAIDs and paracetamol for episodic pain management in line with agreed formularies / guidance • Orthoses / foot wear <u>Stage 3/4:</u> If **<u>not a surgical candidate</u>**: • Footwear modification including semi bespoke shoes or modifications If **<u>surgical candidate:</u>** • Patient needs and wants surgery – fitness for surgery, pre-operative assessment, and discharge planning undertaken – depending on anaesthetics **<u>NOTE - Osteotomy</u>** • 95% operations can undergo regional block (local anaesthetic; GA only at patient's request) • Performed as day case - no Anaesthetist required • Surgery performed by Podiatric Consultant or Orthopaedic Consultant **5 Post-operative management:** • Telephone follow up within 1 week (unless high risk		for an x- ray, face to face with podiatric surgeon **Aseptic Area - dependant on procedure** **Post Anaesthetic facility** **Osteotomy to be performed in theatre with adequate lamina flow facilities**

			patient) • Face to face follow up at 2 weeks for sutures removal and initiation of exercise programme • Follow up at 6 weeks for x-ray and review (face to face or Skype) **6 Outcome Tools** • MOXFQ (The Manchester-Oxford Foot Questionnaire) • PASCOM (Podiatric Audit in Surgery and Clinical Outcome Measure) • EQ5D • SURE **Hub environment (could be spoke but 10 metre walk way required for all patients)**		

Referral reason / Patient presentation	Primary Care Management	Thresholds for Primary Care to initiate a referral	Management Pathway for the Integrated MSK Service	Thresholds for referral to Hospital / In-patient care	Management pathway for Hospital / In-patient care
1st MTPJ pain (vv2) *Pain/Swelling focused around the 1st MtPJ with or without bony swelling usually associated with increasing ankylosis* *Stiffness will create possibility of secondary gait changes leading to pain elsewhere* *Presents with or without Hallux limitus*	**Investigation:** • History • Examination and Assessment • Assess preferred footwear **Diagnostics:** • Bloods to exclude raised serum urate levels – ***follow Rheumatology pathway for Gout (raised urate does not always =gout)*** • X-ray (weight bearing) to assess extent of bone / joint pathology **Management (including condition-specific self-care options):**	**Refer to Integrated MSK Service (Podiatrist / Extended Scope Practitioner / Podiatric Surgeon / Orthopaedic Consultant) if:** • Persistent pain unable to manage through shoe gear change • Increasing deformity, especially with family history. • Pain elsewhere in the foot due to altered foot mechanics • Affecting ability to work • Affecting ADLs	**1 Patient education and information** **2 Assessment and Examination (Extended Scope Practitioner)** • Consideration of Causal Origin (genetic, biomechanical, inflammatory) **3 Investigation & diagnostics:** • Full blood count, ESR, CRP and uric acid required if systemic cause thought likely • Plain film x-ray (weight bearing AP and lateral)	**Offer patient choice of provider if patient needs and wants surgery and is fit for surgery** **If patient needs and wants surgery but is not fit for surgery, refer to GP for further management** **Direct listing possible**	**1 Listed for surgery based on i.e.:** • Pain • Condition limiting function • Patient has been through stage 1 and 2 of the Integrated MSK Service and is confirmed as a surgical candidate **2. Surgical pathway:** • Patient fasted - food 4 hours prior to procedure, liquid 2 hours • IV Cannula sited • Sedation requirements • WHO surgical safety checklist completed

	• Pain relief in line with agreed formularies / guidance • Patient education and information • Recommend stiffer soled shoes • Over the counter orthotics if flat feet		**<u>only if</u>**: ○ Surgical opinion required to assist with planning ○ Assessing for injection therapy ○ Assist with prognosis **4 Management (Podiatrist / Extended Scope Practitioner / Podiatric Surgeon / Orthopaedic Consultant):** • Explanation with leaflet or diagrams as required • Enhanced shoe gear advice <u>Stage 1</u> • Patient education • Manipulation • Orthoses provision <u>Stage 2:</u> • NSAIDs and paracetamol for episodic pain management in line with agreed formularies / guidance • Fan taping as "rescue remedy" • Orthoses / foot wear including stiff soled and over the counter rocker shoes • If joint space is swollen and painful X-ray and consider Steroid injection • If no improvement consider Podiatric Surgeon / Orthopaedic Consultant review <u>Stage 3/4:</u> • Discuss surgical options including Cheilectomy, arthrodesis, osteotomy, arthroplasty		**3. Discharge criteria:** • Neurological checks completed • Pain controlled • Mobile at pre-op level • Medically stable • Provided with appropriate post-operative exercises • **1/52 telephone follow up post op** • **6/52 face to face follow up post op** **Aseptic Area - dependant on procedure** **Post Anaesthetic facility**

			If **not a surgical candidate:** • Footwear modification including semi bespoke shoes or modifications – rocker sole shoes, MBT probably a better option If **surgical candidate:** • Patient needs and wants surgery – fitness for surgery, pre-operative assessment, and discharge planning undertaken **NOTE: Cheilectomy, arthrodesis, osteotomy, arthroplasty** • 95% operations can undergo regional block (local anaesthetic; GA only at patient's request) • Performed as day case - no Anaesthetist required • Surgery performed by Podiatric Consultant or Orthopaedic Consultant **5. Post-operative management:** • Telephone follow up within 1 week (unless risk patient) • Face to face follow up at 2 weeks for sutures removal and exercise programme • Follow up at 6 weeks for x-ray and review (face to face or Skype) • +/- walker boot or rocker shoe **6. Outcome Tools** • MOXFQ (The Manchester-Oxford Foot Questionnaire) • PASCOM (Podiatric Audit in Surgery and Clinical Outcome Measure) • EQ5D		

			• SURE **Hub environment (could be spoke but 10 m walk way required for all patients)**		

Referral reason / Patient presentation	Primary Care Management	Thresholds for Primary Care to initiate a referral	Management Pathway for the Integrated MSK Service	Thresholds for referral to Hospital / In-patient care	Management pathway for Hospital / In-patient care
Morton's Neuroma *Pain described across the forefoot variable from focused to general across whole forefoot with or without paraesthesia or numbness.* *Squeezing the forefoot may reproduce symptoms.* *No traumatic beginning*	**Investigation:** • History • Examination and Assessment • Check shoes for width - tight shoe exacerbate condition • Exclude trauma **Diagnostics:** • **<u>None</u>** **Management (including condition-specific self-care options):** • Patient education and information • Assessment and advice regarding footwear • Over the counter orthotics if flat feet	**Refer to Integrated MSK Service (Podiatrist / Extended Scope Practitioner / Podiatric Surgeon / Orthopaedic Consultant) if:** • Symptoms progressing • Poor foot posture i.e. very flat feet • Numbness paraesthesia	**1 Patient information and education** **2 Assessment and examination:** • Consideration of differential diagnosis: o O/A o Stress o Tumour o Capsulitis/Bursitis o Mono-arthritis o Tendonopathy, flexor plate pathology • Sensation test • Mulder click • End range grind and drawer tests **4 Diagnostics:** • X-ray if joint pathology suspected • Ultrasound – only if failed injection • MRI – only if ultrasound inconclusive and strong symptoms **5 Management (Podiatrist / Extended Scope Practitioner / Podiatric Surgeon / Orthopaedic Consultant):** <u>Stage 1</u> • Enhanced shoe gear advice (wide toe box, low heel)	**Consider referral if:** • Frank tendon rupture or high grade dysfunction suspected • Conservative measures fail **Offer patient choice of provider if patient needs and wants surgery and is fit for surgery** **If patient needs and wants surgery but is not fit for surgery, refer to GP for further management** **Direct listing possible**	**1 Listed for surgery based on i.e.:** • Pain • Condition limiting function • Patient has reached stage 2 of the Integrated MSK Service and is confirmed as a surgical candidate **2. Surgical pathway:** • Patient fasted - food 4 hours prior to procedure, liquid 2 hours • IV Cannula sited • Sedation requirements • WHO surgical safety checklist completed **3. Discharge criteria:** • Neurological checks completed • Pain controlled • Mobile at pre-op level • Medically stable • Provided with appropriate post-operative exercises • **1/52 telephone follow up post op** • **2/52 face to face follow up post op** • **8/52-12/52 x-rays & face to face follow up** **Aseptic Area - dependant on**

			• Orthoses with pronation control and metatarsal dome • Analgesia in line with agreed formularies / guidance • Unguided steroid injection <u>Stage 2</u> • Ultrasound guided injections • Neurectomy • Guided steroid injection • Surgical footwear required • Target injection • Immobilization (air cast) **6 Outcome Tools** • MOXFQ (The Manchester-Oxford Foot Questionnaire) • PASCOM (Podiatric Audit in Surgery and Clinical Outcome Measure) • EQ5D • SURE **Spoke environment**		**procedure** **Post Anaesthetic facility**

Referral reason / Patient presentation	Primary Care Management	Thresholds for Primary Care to initiate a referral	Management Pathway for the Integrated MSK Service	Thresholds for referral to Hospital / In-patient care	Management pathway for Hospital / In-patient care
Tibialis posterior dysfunction **Mostly presents as flat feet** *New onset of pain to postero – medial ankle region, with new onset of flat foot/feet.*	**Investigation:** • History • Examination and Assessment • Exclude nerve root pain ***(see Spine guidelines for management & guidance)*** • Absence of neuro or vascular symptoms • Less than 6 week duration • Too many toes sign, see: orthoinfo.aaos.org • Plain film not indicated	**Refer to Integrated MSK Service (Extended Scope Practitioner / Podiatrist) if:** • Pain affecting day to day activity • If bony pathology suspected • Immediate referral to Integrated MSK Service; appointment within 7 days	**1 Patient information and education** **2 Assessment and examination (Extended Scope Practitioner / Podiatrist):** • Assessment and examination • Consideration of differential diagnosis • Neurovascular component **3 Diagnostics:**	**N/A**	**N/A**

	Diagnostics: None **Management (including condition-specific self-care options):** • Urgent referral to Integrated MSK Service within 7 days • Tip toe test • Pain, swelling • If not picked up, will result in permanent deformity.		• Consideration of furthers tests: • X-ray traumatic - ? fracture component.-bony changes • U/S to confirm/exclude and grade tendon pathology • MR if other tissues involvement suspected • USS if suspected early **4 Management (Extended Scope Practitioner / Podiatrist):** • Aircast walker boot • Consider orthopaedic foot assessment for surgical reconstruction depending on disability and activity level. • If suspected spinal component-refer to Spine ESP • Enhanced Shoe gear • Home exercise program - HEP • Taping • Gait re-training • Orthoses to address mechanical issues • Ultrasound guided steroid injection for tenosynovitis • Blood - inflammatory component- FBC,ESR,CRP & RHF (if indicated) • Richie Brace in chronic condition **Consider Spine pathway if:** • back component **5 Outcome Tools** • PASCOM (Podiatric Audit in Surgery and Clinical Outcome Measure) • EQ5D • SURE • (FAAM) F&A Ability Measure **Spoke environment**		

Referral reason / Patient presentation	Primary Care Management	Thresholds for Primary Care to initiate a referral	Management Pathway for the Integrated MSK Service	Thresholds for referral to Hospital / In-patient care	Management pathway for Hospital / In-patient care
Ankle sprain, medial or lateral. *Common damage in inversion sprain is anterior talo-fibular ligament.* *Ideally should be treated aggressively at first occurrence. Fractures tend to do better than bad sprains because of immobilization when seen in A+E.*	**Investigation:** • History • Examination and assessment • Functional ability • Consider early treatment at A+E **Diagnostics:** • If non-settling and suspect avulsion fracture, consider X-ray • Ultrasound if unstable and diagnosis not clear **Management (including condition-specific self-care options):** • Patient education • As with any sprain protect, rest, ice, compress, elevate (PRICE) • Avoid heat, alcohol, running, massage (HARM) • Advise limitation of exacerbating factors, i.e. sports and work related activities • Over the counter ankle support • Footwear advice • Consider physiotherapy if not settling (6 weeks post injury)	**Refer to Integrated MSK Service (Extended Scope Practitioner):** • Not improving after 6/52 • Severely affecting daily activity • Results of diagnostics indicates specialist assessment. • Suspicion of marked tissue trauma • Not improved after physiotherapy.	**1 Patient education and information** **2 Assessment and Examination (Extended Scope Practitioner):** • Clinical picture • History • Appearance • Results of any tests / imaging • Check for instability (ligamentous) and muscle/tendon pathology **3 Diagnostics:** • X-ray if bone / joint pathology suspected • Ultrasound if tendon / ligament pathology suspected • Consider MRI if: ○ bone pathology likely but X-ray is NAD and not responding (Occult avulsion # or OCD- Osteochondral defect ○ chronicity has set in and possible impingement **4 Management (Extended Scope Practitioner):** • Further rest with bracing • Management of underlying pathomechanics • Steroid if inflammatory component	**Offer patient choice of provider if patient needs and wants surgery and is fit for surgery** **If patient needs and wants surgery but is not fit for surgery, refer to GP for further management** **Pod surgeon if no trauma**	**1 Listed for surgery based on i.e.:** • Recurrent instability • Persistent pain • Functional limitations to ADLs • Confirmed ligament or tendon rupture **2. Surgical pathway: #** • Patient fasted - food 4 hours prior to procedure, liquid 2 hours • IV Cannula sited • Sedation requirements • WHO surgical safety checklist completed **3. Discharge criteria:** • Neurological checks completed • Pain controlled • Mobile at pre-op level • Medically stable • Provided with appropriate post-operative exercises **Aseptic Area - dependant on procedure** **Post Anaesthetic facility**

			• Home Exercise programme • Taping • Consider Podiatric Surgeon / Orthopaedic Consultant review if: ○ Osteochondral defect confirmed ○ Non-manageable impingement ○ Confirmed ligament or tendon rupture- Podsurgeon direct listing option ○ Home exercise programme **5 Outcome Tools** • PASCOM (Podiatric Audit in Surgery and Clinical Outcome Measure) • EQ5D • SURE • (FAAM) F&A Ability Measure **Hub environment – due to imaging requirements, especially MRI**		

Referral reason / Patient presentation	Primary Care Management	Thresholds for Primary Care to initiate a referral	Management Pathway for the Integrated MSK Service	Thresholds for referral to Hospital / In-patient care	Management pathway for Hospital / In-patient care
Metatarsalgia *Pain in the forefoot, generally of non-traumatic origin although it may manifest after surgical rehabilitation; however, stress fracture of MT shaft is not uncommon*	**Investigation:** • History • Examination and Assessment • Exclude nerve root pain ***(see Spine guidelines for management and guidance)*** • Absence of neuro or vascular symptoms • < 6 week duration	**Refer to Integrated MSK Service (Extended Scope Practitioner) if:** • Pain is preventing day to day activity • Frank joint pathology suspected • Failure to create sustained improvement • Symptoms persist > 6 weeks	**1 Patient education and information** **2 Assessment and Examination (Extended Scope Practitioner):** • Assessment and examination • Consideration of differential diagnosis • Neuro-vascular component	**Offer patient choice of provider if patient needs and wants surgery and is fit for surgery** **If patient needs and wants surgery but is not fit for surgery, refer to GP for further management** **Surgical options:** **Osteotomy** **Burstitis**	**1 Listed for surgery based on i.e.:** • Persistent pain • Condition limiting function • Conservative measures and unguided injection failed **2. Surgical pathway:** • Patient fasted - food 4

	• Exclude fracture / joint pathology **Diagnostics:** • X-ray if fracture / joint pathology is suspected **Management (including condition-specific self-care options):** • Patient education • Assessment and advice regarding footwear - avoiding totally flat, high or tight shoes. Encourage supportive / cushioning footwear (trainers) • Protect, rest, ice, compress, elevate (PRICE) • Avoid heat, alcohol, running, massage (HARM) • NSAIDs and simple analgesics in line with agreed formularies / guidance • Reduce overuse of component, activity restriction		**3 Management:** • Suspected spinal component **refer to spine** • Enhanced shoe gear • Home exercise programme - HEP • Gait re-training • Orthoses to address mechanical issues • Steroid injection (<u>without</u> Ultrasound guidance) – <u>note: must have x-ray first</u> • Exclude freibergs- Avascular Necrosis and if stress fracture use Ultrasound to confirm • -Osteobleed • Blood - inflammatory component • Consider air cast boot if necessary **4 Diagnostics:** • Consideration of furthers tests: ○ X-ray if traumatic and query fracture component ○ Freibergs ○ Ultrasound if bursitis or tendosynovitis / nerve entrapment suspected, or capsulitis / plantar plate trauma **5 Further management options:** • Consider Spine pathway if back component • Consider Podiatric Surgeon / Orthopaedic Consultant review if: ○ Conservative measures fail ○ Unguided injection fails	**Freibergs**	hours prior to procedure, liquid 2 hours • IV Cannula sited • Sedation requirements • WHO surgical safety checklist completed **3. Discharge criteria:** • Neurological checks completed • Pain controlled • Mobile at pre-op level • Medically stable • Provided with appropriate post-operative exercises • **1/52 telephone follow up post op** • **2/52 face to face follow up post op** • **8/52-12/52 x-rays (if indicated) & face to face follow up** **Aseptic Area - dependant on procedure** **Post Anaesthetic facility** **Osteotomy to be performed in theatre with adequate lamina flow facilities**

			○ Inflammatory disease suspected **6 Outcome Tools** • MOXFQ (The Manchester-Oxford Foot Questionnaire) • PASCOM (Podiatric Audit in Surgery and Clinical Outcome Measure) • EQ5D • SURE **Spoke environment – due to simple imaging requirements**		

Referral reason / Patient presentation	Primary Care Management	Thresholds for Primary Care to initiate a referral	Management Pathway for the Integrated MSK Service	Thresholds for referral to Hospital / In-patient care	Management pathway for Hospital / In-patient care
Midfoot pain Pain in the midfoot, generally of non-traumatic origin.	**Investigation:** • History • Examination and Assessment • Exclude nerve root pain ***(see Spine guidelines for management and guidance)*** • Absence of neuro or vascular symptoms • < 6 week duration • Exclude fracture **Diagnostics:** • X-ray if bony / joint pathology suspected **Management (including condition-specific self-care options):** • As with any sprain protect, rest, ice, compress, elevate (PRICE) • Avoid heat, alcohol,	**Refer to Integrated MSK Service (Extended Scope Practitioner) if:** • Joint pathology suspected • Failure to create sustained improvement • Symptoms more than 6 weeks ***NB If neuropathic arthropathy (Charcot) suspected, X-ray and refer urgently to orthopaedics via A&E***	**1 Patient education and information** **2 Assessment and Examination (Extended Scope Practitioner):** • Assessment and examination • Consideration of differential diagnosis • Neuro-vascular component • Provocative testing of midfoot joints and extensor tendons **3 Diagnostics:** ○ X-ray if bone joint pathology suspected ○ Ultrasound if tendon pathology suspected (<u>note:</u> this will show TMT and tarsao-tarsal o/a and capsulitis more clearly than x-ray)	**Offer patient choice of provider if patient needs and wants surgery and is fit for surgery** **If patient needs and wants surgery but is not fit for surgery, refer to GP for further management** **Osteotomy** **Excision of bursa**	**1. Surgical pathway:** • Patient fasted - food 4 hours prior to procedure, liquid 2 hours • IV Cannula sited • Sedation requirements • WHO surgical safety checklist completed **2. Discharge criteria:** • Neurological checks completed • Pain controlled • Mobile at pre-op level • Medically stable • Provided with appropriate post-operative exercises • After 1 week-phone • 2 weeks face to face • 8 weeks X-ray and face to face • 12/52 follow up **Lamina Flow Theatre / Aseptic Area - dependant on**

	running, massage (HARM) • NSAIDs and simple analgesics in line with agreed formularies / guidance • Activity restriction		**4 Management:** • Footwear advice • Protect, rest, ice, compress, elevate (PRICE) • Avoid heat, alcohol, running, massage (HARM) • Joint mobilizations • Taping • Orthoses • Steroid injection (Note: x-ray guided is gold standard. 'Blind' injection is not recommended) • Consider Podiatric Surgeon / Orthopaedic Consultant review if: ○ failed conservative treatment ○ failed steroid injection ○ suspicion of systemic inflammatory component ○ fracture seen and not responding **5 Outcome Tools** • MOXFQ (The Manchester-Oxford Foot Questionnaire) • PASCOM (Podiatric Audit in Surgery and Clinical Outcome Measure) • EQ5D • SURE **Spoke environment – due to simple imaging requirements**		**procedure** **Post Anaesthetic facility**

Referral reason / Patient presentation	Primary Care Management	Thresholds for Primary Care to initiate a referral	Management Pathway for the Integrated MSK Service	Thresholds for referral to Hospital / In-patient care	Management pathway for Hospital / In-patient care

Limb length difference (LLD) ***May present as back pain*** ***Unilateral back pain***	**Investigation:** • History - especially hip dysplasia, total hip replacement and fracture • Examination and Assessment **Management (including condition-specific self-care options):** • Consider over the counter heel raise for short side (shoe shops, some pharmacies, online)	**Refer to Integrated MSK Service (Extended Scope Practitioner) if:** • LLD suspected ***Note:*** ***it is difficult to accommodate large LLDs with in-shoe devices. For these cases patients will need Orthotics*** *If patient requires a replacement orthotic Triage to Integrated MSK Service to see an Orthotist*	**1 Patient education and information** **2 Assessment and Examination (Extended Scope Practitioner):** • Assessment and examination • Consideration of differential diagnosis • Neuro-vascular component • Clinical measurement of LLD **3 Management:** • Provision of in-shoe raise on short side • Orthoses if necessary • Footwear advice • Consider Orthotist review if: ○ If difference too great to accommodate in shoe surgical appliance for provision / adaptation of footwear **4 Outcome Tools** • PASCOM (Podiatric Audit in Surgery and Clinical Outcome Measure) • EQ5D • SURE **Spoke environment**	**N/A**	**N/A**

Referral reason / Patient presentation	Primary Care Management	Thresholds for Primary Care to initiate a referral	Management Pathway for the Integrated MSK Service	Thresholds for referral to Hospital / In-patient care	Management pathway for Hospital / In-patient care

Peroneal tendinopathy/non-traumatic lateral ankle pain *Pain/dysfunction to the lateral ankle along the line of the peroneal muscle and tendons*	**Investigation:** • History • Examination and Assessment • Exclude nerve root pain ***(see Spine guidelines for management and guidance)*** • Absence of neuro or vascular symptoms • < 6 week duration • Absence of single traumatic episode **Diagnostics:** • Muscle power testing (note: tendon may be felt to sublux) **Management (including condition-specific self-care options):** • Supportive footwear, small heel if appropriate • As with any sprain protect, rest, ice, compress, elevate (PRICE) • Avoid heat, alcohol, running, massage (HARM) • NSAIDs and simple analgesics in line with agreed formularies / guidance • Reduce overuse component, activity restriction	**Refer to Integrated MSK Service (Extended Scope Practitioner) if:** • Failure to create sustained improvement • Continuing lateral ankle instability (sprains) • Pain preventing day-to-day activity • Symptoms > 6 weeks	**1 Patient education and information** **2 Assessment and Examination:** • Muscle power / flexibility testing • Ankle ligament assessment • Sural nerve entrapment • Exclude bone / joint pathology **3 Diagnostics:** • X-ray • Ultrasound **4 Management:** • Suspected spinal component • Protect, rest, ice, compress, elevate (PRICE) • Avoid heat, alcohol, running, massage (HARM) • Taping • Mobilizations • Proprioceptive / strengthening regime • Orthoses / footwear • Steroid injection • Consider Podiatric Surgeon / Orthopaedic Consultant review if: • Suspected ligament / tendon tear-direct list opportunity • Suspected avulsion fracture • Severe joint pathology-probably orthopaedics • Suspected systemic inflammatory component • Peroneal tear **5 Outcome Tools**	**Offer patient choice of provider if patient needs and wants surgery and is fit for surgery** **If patient needs and wants surgery but is not fit for surgery, refer to GP for further management**	**1 Listed for surgery based on i.e.:** • Pain • Condition limiting function • Conservative measures and steroid injection failed • Suspected ligament / tendon tear or avulsion fracture or severe joint pathology **2. Surgical pathway:** • Patient fasted - food 4 hours prior to procedure, liquid 2 hours • IV Cannula sited • Sedation requirements • WHO surgical safety checklist completed **3. Discharge criteria:** • Neurological checks completed • Pain controlled • Mobile at pre-op level • Medically stable • Provided with appropriate post-operative exercises **Lamina Flow Theatre / Aseptic Area - dependant on procedure** **Post Anaesthetic facility**

			• MOXFQ (The Manchester-Oxford Foot Questionnaire) • PASCOM (Podiatric Audit in Surgery and Clinical Outcome Measure) • EQ5D • SURE **Spoke environment – due to simple imaging requirements**		
Referral reason / Patient presentation	**Primary Care Management**	**Thresholds for Primary Care to initiate a referral**	**Management Pathway for the Integrated MSK Service**	**Thresholds for referral to Hospital / In-patient care**	**Management pathway for Hospital / In-patient care**
Achilles Tendinopathy	**Investigation:** • History • Examination and Assessment • Exclude nerve root pain ***(see Spine guidelines for management and guidance)*** • Absence of neuro or vascular symptoms • < 6 week duration • Absence of single traumatic episode **Diagnostics:** • Muscle power testing (note: tendon may be felt to sublux) **Management (including condition-specific self-care options):** • Supportive footwear, small heel if appropriate • As with any sprain protect, rest, ice, compress, elevate (PRICE) • Avoid heat, alcohol, running, massage (HARM) • NSAIDs and simple	• **Triage to MSK (physio)** • **Symptoms > 6 weeks**	• Mobilise exercise, if no improvement 3-6 months USS then Podiatry ESP & USS • High Volume Injection (not for chronic patients*)- is there an evidence base for this?*requires further MDT discussion* • Orthotics • Gel sleeve • Cast/immobilise • Extracorporeal Shock Wave Therapy • Volumising injections		

	analgesics in line with agreed formularies / guidance • Reduce overuse component, activity restriction • Suspected full rupture of tendon refer to A & E				

Foot and Ankle group 12th December 2013

Peter Devlin (BICS, Clinical Director)

Ian Francis (MIP, Consultant Radiologist)

Paul Keeping (WHST Orthotist)

Richard Cruse (SCT, ESP Podiatrist)

James Alvey (SCT, Consultant Podiatric Surgeon)

Di Finney (BICS /SCT Rheumatology Consultant Nurse)

Andy Razell (SCT Lead Podiatrist)

Neil Simmonite (ESHT Clinical Lead)

Helen Harper-Smith (ESHT ESP)

Foot and Ankle group 15th July 2014

Natalie Blunt (BICS, Service Manager)

Peter Devlin (BICS, Clinical Director)

Kasia Kaczmarek (BICS, Integrated Care Manager)

Johan Holte (BICS, Consultant Physiotherapist)

Richard Bell (SCT, Clinical Service Manager)

Iben Altman (SCT, Chief Pharmacist)

Graham Hadlow (SCT, ESP)

Andy Razzell (SCT, Lead Podiatrist)

Richard Cruse (SCT, Podiatrist)

James Alvey (SCT, Consultant Podiatric Surgeon)

John Bush (BSUH, Consultant Radiologist)

Anita Vincent (SASH, Service Manager)

Rachel Dixon (Horder Healthcare, Clinical Director)

(***total email distribution list:*** *Andy Razzell, Anita Vincent, Avadhoot Kantak, Natalie Blunt, David Atkins, Peter Devlin, Graeme Hadlow, Johan Holte, Ian Francis,, Iben Altman, James Alvey, John Bush, Ciara Jones, Natasha Cracknell, Penny Bolton, Simon Oates, Kasia Kaczmarek, Laura Finucane, Mohan Lal, Sally Dando, Natasha Hossain, Rachel Dixon, Richard Bell, Richard Cruise)*