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/**

- 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 Specialist In-patient care	Management pathway for Specialist In-patient care
OA 1st CMCJ ○ *OA thumb* ○ *Thumb arthritis* ○ *Base of thumb pain*	**Examination, history & assessment** • Symptom longevity and severity • Assess for activities of daily living limitation • Co-morbidities **Investigations** • Diagnostics - Thumb x-ray (AP / lateral of CMCJ +/- wrist **if indicated** ie for severe symptoms) **Management (including condition-specific self-care options):**	**Refer to DES for injection if clear diagnosis and early presentation -** if no response to one injection refer to Integrated MSK Service **Refer to Integrated MSK Service (Extended Scope Practitioner / Hand Surgeon) if:** • Diagnostically uncertain • Course of NSAIDs and / or analgesia has been trialled (except where contra-indicated) and symptoms severe • To discuss surgical options **Rheumatology OT** for: • joint protection advice	**1. Examination, history and assessment** • Holistic assessment • Symptom longevity and severity, and previous management • Assess for activities of daily living limitation • Co-morbidities **2. Investigation** • AP / lateral of CMCJ + / - Wrist X-ray if not already done **3. Management** • Condition specific Patient	**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:** **Arthroplasty** **Fusion** **Excision of the bone** **Surgery: unless 12 months of pain/unless severe pain** **No direct listing** **Regional or GA** **Competency of anaesthetist :**	**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 advise (including exercise) • Rehab and Post intervention

	• Explanation of cause and natural history • Pain relief in line with agreed formularies / guidance - for a minimum of 2 weeks • Review resolution of symptoms and activities of daily living • Advice on thumb mobilisation but not overuse and joint protection advice • Discuss treatment options **Condition specific Patient Information Leaflet should be given to the patient (*as appropriate*).** **bssh.ac.uk thumb arthritis** Protecting your joints | Arthritis Research UK	• ADL assessment • Splints • Exercise • gadgets if patient does not want surgery or injection / not suitable for injection Flag ?Rheuma / ?HT If suspect inflammatory following treatment is the same	Information Leaflet should be given to the patient (as appropriate) - bssh.ac.uk thumb arthritis • Explanation of cause and natural history • Advice on analgesia and joint protection • Treatment options including splinting, exercises, injection and surgical intervention • Consider review by Specialist OT **/** Rheumatology OT (depending on local arrangements) for: ○ Joint protection advice ○ ADL assessment ○ Splints ○ Exercise gadgets • Consider review by Hand Surgeon if: ○ Intrusive symptoms after all conservative management options have been tried or discussed **AND** the patient wants surgery ○ Consider unusual symptoms > 12m **4. Outcome Tools** • Patient Evaluation Measure (PEM) Outcome Tool • SURE **HUB OR SPOKE ENVIRONMENT WITH ACCESS TO XRAYS AND MDT SPACE (2 rooms)**	**This is an issue that needs addressing**	• Hand therapy at 2/52 and splint • Face to face follow up in 4/52 with consultant **Aseptic Area - dependant on procedure** **Post Anaesthetic facility** GA or regional block
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 Specialist In-patient care**	**Management pathway for Specialist In-patient care**

Carpal Tunnel Syndrome
 	
A common disorder resulting in a varying spectrum of symptoms including pain in the wrists, tingling and numbness in the fingers. Prognosis can vary. Even if untreated 34%-49% can significantly improve or resolve spontaneously.
 	
BEST 1 BSSH CTS Education resource 2009
	Examination, history and assessment
	
	• Symptom longevity and severity
	• Co-morbidities
	• Tinel's and Phalen's tests
	• Assess for sensory loss defined as 'objective evidence of reduced sensation' - more likely to be permanent or fixed in severe and late presentation
	• Assess for thenar wasting – test thumb abduction power
	• Assess for activities of daily living limitation
	• Neurological examination if neck symptoms
	
	Investigations
	
	• **None** - nerve conduction studies **are not** indicated in primary care
	
	Management (including condition-specific self-care options):
	
	• Explanation of cause and natural history
	• Explanation of approaches to treatment
	• Pain relief in line with agreed formularies / guidance
	• Night straight (neutral) splint for patients with night time symptoms
	• Advice on joint protection
	• Advice on mobilisation but not overuse
	• Postural advice dependent on occupation ergonomics
	• Review and monitor for resolution of symptoms for up to 3 months
	• Intervention with injection for unresolving or moderate to severe symptoms
	• Evidence review of
		Refer to DES for injection if:
		
		(Evidence needed) NICE + PDA
		
		• diagnosis clear and unresolved mild symptoms
		• patient agrees to injection
		
		Refer to Integrated MSK Service (Extended Scope Practitioner / Hand Surgeon) if
		
		• Diagnostically not clear
		• Moderate to severe symptoms
		• Patient wants surgery or to discuss surgical options
		
		Refer to Integrated MSK Service (Extended Scope Practitioner) as urgent appointment within 2 weeks if:
		
		• Thenar wasting
		• Fixed sensory loss
		
		Refer to Integrated MSK Service Spine pathway if:
		
		• Non localised symptoms, with neck pain and weakness +/- muscle wasting & numbness
			1. Assessment and Examination (Extended Scope Practitioner):
			
			• Holistic assessment
			• Symptom longevity and severity, and previous management
			• Provocative tests
			• Assess for sensory loss - more likely to be permanent or fixed in severe and late presentation
			
			2. Diagnostics/ investigations
			
			• Nerve conduction studies are only required to define a diagnosis
			• Consider MR to exclude neck pathology if double crush
			
			3. Management
			
			• Condition specific Patient Information Leaflet should be given to the patient - arthritis research uk carpal tunnel syndrome
			• Explanation of cause and natural history of condition
			• Splint(s) for:
			  ○ Night symptoms
			  ○ Mild/moderate symptoms with activity
			  ○ No sensory loss defined as objective evidence of reduced sensation
			• Advice on nerve stretches – median nerve glides exercises
			• Steroid Injection(s) if:
			  ○ Dependent on severity of symptoms
			  ○ Diagnostic aid
			  ○ Patient **doesn't** want surgery
			• **Consider Integrated MSK Service Spine pathway if:**
				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
				
				CT decompression under local
				
				MDT evidence review
					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 advise (including exercise)
					• Post op- 2/52 follow up with a Practice Nurse for a wound check
					• 6/52 follow up with a Hand Therapist
					
					Aseptic Area - dependant on procedure
					Post Anaesthetic facility

	injections for CTS **Condition specific Patient Information Leaflet should be given to the patient (*as appropriate*). (NICE / BSSH)** **arthritis research uk carpal tunnel syndrome**		○ Suspicion of neck involvement or double crush syndrome suspected • Consider review by Hand Surgeon if: ○ Atypical symptoms ○ Diagnostic confusion ○ Patient wants and needs surgery - fitness for surgery, pre-operative assessment, and discharge planning undertaken ○ **Complete CTS Patient Decision Aid** **4. Outcome Tools n** ○ Boston Carpal Tunnel Questionnaire Outcome Tool ○ DASH ○ SURE **HUB OR SPOKE ENVIRONMENT WITH MDT SPACE (2 rooms)**		
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 Specialist In-patient care**	**Management pathway for Specialist In-patient care**
Trigger Finger / Thumb *A painful condition in which a finger or thumb clicks or locks as it is flexed.* *Thickening of the mouth of a tendon tunnel leads to roughness and catching of the tendon. People with insulin-dependent diabetes are especially prone.* *Triggering can start after an injury such as a knock on the hand. The pain can be*	**Examination, history and assessment** • Pain level • Longevity of symptoms • Assess for limitations of range of movement and ADLs • Co-morbidities **Investigations** • **None** **Management (including condition-specific self-care**	**Refer to DES for injection if:** • diagnosis clear • patient agrees to injection **Refer to Integrated MSK Service (Extended Scope Practitioner / Hand Surgeon) if:** • Diagnostically unclear • Significant hand co-morbidity • If patient does not want injection or surgery • To discuss surgical options	**1. Assessment and examination (Extended Scope Practitioner)** • Pain level • Longevity of symptoms • Symptom severity • Previous management • Assess for limitations of range of movement and ADLs • Co-morbidities **2. Management** • Condition specific Patient	**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** **Surgery:** - Local block release - Day case	**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

aggravated by hand use. *It can occur in rheumatoid arthritis due to tendon nodules. It is not caused by or associated with osteoarthritis* **BSSH trigger finger guidelines 2009**	**options):** • Explanation of cause and natural history • Re-assess for limitations on range of movement and ADLs • Self-massage the nodule for up to 6 weeks and monitor resolution of symptoms • Consider steroid injection • Self-management advice • Condition specific Patient Information Leaflet should be given to the patient - bssh.ac.uk trigger finger	• Failure to respond to conservative treatment (i.e. up to 2 steroid injections)	Information Leaflet should be given to the patient as appropriate. bssh.ac.uk trigger finger • Explanation of cause and natural history • Advice on treatment options • Advice on surgical intervention options • Steroid Injection(s) • Consider review by Hand Surgeon if: ○ Failure to respond to conservative measures (i.e. up to 2 steroid injections) ○ Where the patient has a fixed deformity that cannot be corrected ○ Patient wants and needs surgery - fitness for surgery, pre-operative assessment, and discharge planning undertaken **3. Outcome Tools** • DASH • PEM • SURE **HUB OR SPOKE ENVIRONMENT WITH MDT SPACE (2 rooms)**		• Medically stable • Provided with appropriate post-operative advise (including exercise) • Post op- 2/52 follow up with a Practice Nurse • 6/52 follow up with a Hand Therapist **Aseptic Area - dependant on 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 Specialist In-patient care	Management pathway for Specialist In-patient care
Dupuytren's Disease *This is a condition characterised by fibrosis of the palmar aponeurosis leading to contracture of the fingers. It is*	**Examination, history and assessment** • Longevity of problem and symptoms	**Refer to Integrated MSK Service (Extended Scope Practitioner) if:** • Diagnostically uncertain	**1. Examination, history & assessment (Extended Scope Practitioner / Hand Surgeon)** • Careful history of symptoms	**Offer patient choice of provider if patient needs and wants surgery and is fit for surgery** **If patient needs and wants**	**1. Surgical pathway:** • Patient fasted - food 4 hours prior to procedure, liquid 2 hours • IV Cannula sited

often confused with trigger finger but whilst it can be painful early on this then resolves. The contracture is also not correctable at any stage – unlike trigger finger.
 	
This seems to run in families and has no known cause, but may be associated with diabetes, smoking and alcohol excess
	• Family history
	• Check for nodule, cord, finger range of movement
	• Assess for limitations of range of movement and ADLs
	
	Investigations
	
	• **None**
	
	Management (including condition-specific self-care options):
	
	• Explanation of cause and natural history
	• Advice on treatment options
	• Advice on surgical intervention
	• Patient to self monitor the degree of contracture if it does not meet the requirement for surgical intervention
	• The guidelines for minimum degree of contracture required for surgery:
	  ○ > 10 degrees PIP and / or
	  ○ > 30 degrees MCP
	  Although the main indications for contracture correction are:
	  1) Functional compromise
	  2) Progression of contracture
	• Condition specific Patient Information Leaflet should be given to the patient - **bssh.ac.uk dupuytrens disease**
		Refer to Integrated MSK Service (Hand Surgeon) for surgical intervention only if fulfils the following criteria:
		
		• a flexion contracture exceeding 30 degrees at the metacarpophalanageal joint
		• and / or a contracture exceeding 10 degrees at the proximal interphalangeal joint
		• and patient wants surgery /
		• or patient would like xiapex treatment
			and assessment of the patient taking into account differential diagnoses
			• Symptom longevity and severity
			• Previous management
			• Table top test
			• Assess for limitations on ROM and ADLs
			
			2. Management
			
			• Condition specific Patient Information Leaflet should be given to the patient - **bssh.ac.uk dupuytrens disease**
			• Explanation of cause and natural history
			• Explanation of approaches to treatment
			• Advice on heat and stretching
			• Self monitoring advice
			• Consider review by Specialist OT / Rheumatology OT (depending on local arrangements) if ADL's effected
			• Consider review by Hand Surgeon for surgical intervention only if fulfils the following criteria:
			  ○ a flexion contracture exceeding 30 degrees at the metacarpophalanageal joint
			  ○ and / or a contracture exceeding 10 degrees at the proximal interphalangeal joint
			  ○ Patient wants and needs surgery - fitness for surgery, pre-operative assessment, and discharge planning undertaken
			• Consider referral to QVH for
				surgery but is not fit for surgery, refer to GP for further management	• 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 advise (including exercise)
					• Post op- early/wound check 1-2/52
					• Splint provision
					• Hand Therapy at 1-2/52
					
					Aseptic Area - dependant on procedure
					Post Anaesthetic facility

			Xiapex only if fulfils the following criteria: ○ a flexion contracture exceeding 30 degrees at the metacarpophalanageal joint ○ and / or a contracture exceeding 10 degrees at the proximal interphalangeal joint ○ patient understands pros & cons of xiapex tretment **3. Outcome Tools** • **EQ5D** • **SURE** **HUB OR SPOKE ENVIRONMENT WITH MDT SPACE (2 rooms)**		
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 Specialist In-patient care**	**Management pathway for Specialist In-patient care**
De Quervain's Tendonitis *Thumb tendonitis of extensor pollicis brevis and abductor pollicis longus within the 1st dorsal compartment*	**Examination, history & assessment** • Assess for limitations of range of movement and ADLs • Pain level **Investigations** • **None** **Management (including condition-specific self-care options):** • Avoid repetitive tasks • Advice on mobilisation but not overuse • Advice on the use of over the counter thumb splints • Course of analgesia and /	**Refer to DES for injection if:** • diagnosis clear • patient agrees to injection **Refer to Integrated MSK Service (Extended Scope Practitioner) if:** • Diagnostically uncertain • Failed injection • Course of NSAIDs and / or analgesia has been trialled (except where contra-indicated) • Discuss surgical options	**1. Examination, history & assessment (Extended Scope Practitioner)** • Holistic assessment • Finkelsteins manoeuvre • Assess ADLs • Careful history of symptoms and assessment of the patient taking into account differential diagnoses • Symptom longevity and severity • Previous management **2. Management** • Condition specific Patient Information Leaflet should be given to the patient - **bssh.ac.uk dequervains**	**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. 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 advise (including exercise)

	or NSAIDs for a minimum of 2 - 3 weeks in line with agreed formularies / guidelines • Review for resolution of symptoms and monitor subjectively in line with ADLs • Condition specific Patient Information Leaflet should be given to the patient - **bssh.ac.uk dequervains syndrome**		**syndrome** • Analgesia advice - NSAIDs and / or analgesia (except where contra-indicated) • Splint(s) - different types to be trialled • Steroid Injection(s) • Functional analysis / retraining – consider review by Hand Therapy • Consider review by Hand Surgeon for surgical discussion if: ○ Intrusive symptoms after all conservative management options have been tried ○ Patient wants and needs surgery - fitness for surgery, pre-operative assessment, and discharge planning undertaken **3. Outcome Tools** • Patient Evaluation Measure (PEM) Outcome Tool • EQ5D • SURE **HUB OR SPOKE ENVIRONMENT WITH MDT SPACE (2 rooms)**		**Aseptic Area - dependant on 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 Specialist In-patient care**	**Management pathway for Specialist In-patient care**
Wrist Pain *Wrist pain is extremely common and there are many common causes of this problem. It is important to make an accurate diagnosis of the cause of your symptoms so that appropriate treatment can be directed at the cause.*	**Examination, history & assessment** • Assess for limitations of range of movement and ADLs • Pain level • Signs of synovitis, heat swelling, stiffness • History of trauma	**Refer to Integrated MSK Service (Hand Surgeon) as urgent if:** • **positive history of trauma within 6 weeks** **Refer to Integrated MSK Service (Extended Scope Practitioner) if:** • Diagnostically uncertain	**1. Examination, history & assessment (Extended Scope Practitioner)** • Holistic assessment • Assess ADLs • Careful history of symptoms and assessment of the patient tasking into account differential diagnoses • Symptom longevity and	**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 • Procedure dependent upon exact diagnosis • Patient wants and is fit for surgery **2. Surgical pathway:**

	Investigations
	
	• **<u>None</u>**
	
	Management (including condition-specific self-care options):
	
	• Course of analgesia and / or NSAIDs in line with agreed formularies / guidance for a minimum of 6 weeks
	• Review resolution of symptoms / monitor subjectively in line with ADLs
	• Advice on rest, cold compress
	• Initiate gentle exercise of the wrist
	• 2 week symptom review if history of trauma
	• Patient education
	• Condition specific patient information leaflet
		• Course of NSAIDs and / or analgesia has been trialled (except where contra-indicated) for 6 weeks
		
		Refer to Integrated MSK Service Rheumatology pathway if:
		• Suspected new inflammatory arthritis and not resolving with oral NSAID's
		
		Refer to Integrated MSK Service Shoulder and Elbow pathway if:
		
		• Ulnar nerve symptoms
			severity
			• Previous management
			
			2. Investigations
			
			If suspected synovitis:
			• Full blood count, uric acid (repeat if symptoms resolves if normal), U&E, CRP, ESR, Rheumatoid factor **<u>not</u>** ANA
			• Diagnostics depending upon symptoms XR, MRI or consider MRA (10%-20%)
			• Specialist OT / Rheumatology OT (depending on local arrangements)
			
			3. Management
			
			• Patient education including condition specific patient information leaflet
			• Provide conservative management as clinically appropriate
			• Consider review by Rheumatology Consultant if suspected new inflammatory arthritis
			• Consider review by Specialist OT / Rheumatology OT (depending on local arrangements) if having difficulty with ADLs
			• Consider review by Hand Surgeon if:
			  • surgical intervention indicated
			  • non-obvious / unconfirmed diagnosis 20-30%
			  • Patient wants and needs surgery - fitness for surgery, pre-operative assessment, and discharge planning undertaken
			• Consider following the
					• 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 advise (including exercise)
					• Hand Therapy at 1-2/52
					
					Lamina Flow Theatre / Aseptic Area - dependant on procedure
					Post Anaesthetic facility

			Shoulder and Elbow pathway if: • Ulnar nerve symptoms **4. Outcome tools** • Patient Rated Wrist / Hand Evaluation Outcome Tool • EQ5D • SURE **HUB OR SPOKE ENVIRONMENT WITH MDT SPACE (2 rooms)**		
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 Specialist In-patient care**	**Management pathway for Specialist In-patient care**
Ganglion Wrist *These common benign growths mainly affecting the wrist may change in size or even disappear completely, and may or may not be painful.* *Studies have shown that 38% of people who had surgery expressed cosmetic concerns, 28% were concerned about malignancy, and only 26% presented because of pain. These may simply be exchanging an unsightly lump with a 50% chance of spontaneous resolution for an unsightly and permanent scar.* *Curr Rev Musculoskelet Med. 2008 December; 1(3-4): 205–211.* *Ganglion cysts of the wrist: pathophysiology, clinical picture, and management*	**Examination, history & assessment** • Longevity and severity of symptoms • Assess for limitations on range of movement and ADLs **Investigations** • **None** **Management (including condition-specific self-care options):** • If pain free and not affecting range of movement and ADLs: • Advise that these are best left without any intervention • Do not aspirate • Patient to self monitor • Condition specific Patient Information Leaflet should be given to the patient - **bssh.ac.uk ganglion cysts**	**Refer to Integrated MSK Service (Extended Scope Practitioner) if:** • Early presentation and patient concerned • Affecting ADLs and range of movement but not severe pain • Diagnostic doubt **Refer to Integrated MSK Service (Hand Surgeon) if:** • If there is severe pain or significant size or interference with ADLs • Patient wants surgery **Note: Prior Approval Procedure (PAP) - Surgery for ganglion of the wrist will only be funded for patients who have fulfilled agreed criteria as below:** ○ there are symptoms associated with the ganglia such as pain, increase in size and loss of sensation in certain parts of the hand,	**1. Examination, history & assessment (Extended Scope Practitioner / Hand Surgeon)** • Holistic assessment • Symptom longevity and severity • Previous management • Assess ADLs • If dorsal - check no instability symptoms **2. Investigations** Consider USS use MR or CT if diagnostic uncertainty **3. Management** • Condition specific Patient Information Leaflet should be given to the patient - **bssh.ac.uk ganglion cysts** • Advice re treatment options • Use of splints to decrease discomfort with activities • Advice re analgesia unless contra indicated • Consider review by Hand Surgeon if:	**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. 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 advise (including exercise) **Aseptic Area - dependant on procedure** **Post Anaesthetic facility**

		neurological loss or weakness of the wrist with the ganglion, and restriction of work or hobbies because of the ganglia ○ patients are aware that most ganglia resolve spontaneously over time ○ Patients are aware of the complications of excision such as scar tenderness, stiffness or numbness, and likelihood of recurrence	○ Severe pain ○ Significant size ○ Interference with ADLs ○ Patient wants and needs surgery - fitness for surgery, pre-operative assessment, and discharge planning undertaken **Note: Prior Approval Procedure (PAP) (see earlier note about PAP) - Surgery for ganglion of the wrist will only be funded for patients who have fulfilled agreed criteria as below:** ○ there are symptoms associated with the ganglia such as pain, increase in size and loss of sensation in certain parts of the hand, neurological loss or weakness of the wrist with the ganglion, and restriction of work or hobbies because of the ganglia ○ patients are aware that most ganglia resolve spontaneously over time ○ Patients are aware of the complications of excision such as scar tenderness, stiffness or numbness, and likelihood of recurrence **3. Outcome tools** • EQ5D • SURE **HUB OR SPOKE ENVIRONMENT WITH MDT SPACE (2 rooms)**		

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 Specialist In-patient care**	**Management pathway for Specialist In-patient care**

Lumps and bumps *Lumps and bumps and small tumours of the hand and wrist are common and usually benign this is not an exhaustive list* **Mucous cysts - Hand Surgeon** **Garrods pads** **Seed Ganglion - Hand Surgeon** **Giant cell tumour – Hand Surgeon** **Neurofibroma** **Heberdens nodes** **Mass ?malignancy** **Skin lesions such as BCC/SCC need Dermatology referal**	**Examination history and assessment** • Longevity • Family history • History of trauma • Pain level • Signs of synovitis, heat swelling, stiffness, red flags • Assess for limitations of range of movement and activities of daily living. **Investigations** • Consider X-ray if this will change your decision to refer or not **Management (including condition-specific self-care options):** If pain free and not affecting range of movement and ADLs: • Advise that these are best left without any intervention • Patient to self monitor for size and interference with function • Refer if a diagnosis cannot be made	**Urgent Sarcoma 2WW referral form for suspected malignancy if the lump fulfils <u>any</u> of the following criteria:** • **Growing or greater than 5cm** • **Painful** • **Feels deep to muscle** • **Has recurred following excision** **Refer to Integrated MSK Service (Extended Scope Practitioner) if:** • Patient concerned • No suspicion of malignancy **Refer to Integrated MSK Service Rheumatology pathway OT** or specialist OT if effecting ADLs etc.	**1. Examination, history and assessment (Extended Scope Practitioner)** • Holistic assessment • Symptom longevity and severity • Previous management • Assess ADLs • Check no instability symptoms **2. Investigations** Consider USS use MR or CT if diagnostic uncertainty **3. Management** • Advice re treatment options • Use of splints to decrease discomfort with activities • Advice re analgesia unless contra indicated **3. Outcome tools** • EQ5D • SURE • USS • X-Ray **HUB OR SPOKE ENVIRONMENT WITH MDT SPACE (2 rooms)**	**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 Specialist In-patient care**	**Management pathway for Specialist In-patient care**

Finger pain
 	
This is commonly caused by osteoarthritis but can also be caused by inflammatory arthritis strains and injury.
 	
Symptoms can involve the distal or proximal interphalageal joints or the meta carpophalangeal joints
	Examination, history & assessment
	
	• Pain level
	• ADLs
	• ROM
	• Signs of inflammatory arthritis:
	  ○ Early morning stiffness for more than 30 minutes
	  ○ Obvious painful swollen joint (redness / erythema more noticeable with gout and pain reaching its peak in less than 24 hours)
	  ○ Single or several joint pain or swelling; small / large joints involved and distribution
	  ○ **Rule out red flags** and systemic symptoms (ie rashes)
	• Co-morbidities
	• Injury
	• Patient temperature
	
	Investigation
	
	• If suspected inflammatory arthritis:
	  ○ Full blood count, uric acid (repeat after symptoms resolves if normal), U&E, CRP, ESR, Rheumatoid factor
	• **No imaging necessary** unless suspected injury
	
	Auto-antibodies blood tests are unlikely to be helpful (because there are frequent false positives), unless specific indications of connective tissue disorder such as:
	
	- dry eyes
	- dry mouth
		Refer to A&E if penetrating injury in last 2 weeks and any sepsis suspected
		
		Refer to Integrated MSK Service (Hand Surgeon) as urgent if:
		• **positive history of trauma within 2 weeks**
		
		Refer to DES for injection if:
		• diagnosis clear
		• patient agrees to injection
		
		Refer to Integrated MSK Service Rheumatology pathway if:
		• Suspected inflammatory arthritis first episode and symptoms are more than 10 days
		• Not responding to primary care management
		• If no response to one injection refer to MSK ICATS
		
		Refer to Integrated MSK Service (Extended Scope Practitioner) if:
		• Diagnostically unclear
		• Moderate to severe symptom and course of NSAIDs and / or analgesia has been trialled (except where contra-indicated)
		• If no signs of inflammatory arthritis
		• Injury greater than 4 weeks ago
		• If affecting ADLs and range of movement
		• Patient **does not** want surgery
		
		Refer to Integrated MSK Service (Hand Surgeon) if:
		• Trauma within 6 weeks
		• Surgical intervention/ injection indicated **and** patient wants these
			1. Examination, history & assessment (Extended Scope Practitioner)
			
			• Holistic assessment
			• Symptom longevity and severity
			• Previous management
			• ADLs
			• Range of movement
			• Signs of inflammatory arthritis
			• Co-morbidities
			• Injury
			
			2. Investigation
			
			• Patient temperature
			• If suspected inflammatory arthritis:
			  • Full blood count, uric acid (repeat if symptoms resolves if normal), U&E, CRP, ESR, Rheumatoid factor, **NOT ANA** unless:
			  ▪ dry eyes
			  ▪ dry mouth
			  ▪ photosensitive rash
			  ▪ significant alopecia
			  ▪ recurrent miscarriage
			• **No imaging necessary** unless suspected injury use XRay consider MR if uncertain diagnosis
			
			3. Management
			
			• Condition specific Patient Information Leaflet should be given to the patient - **bssh.ac.uk finger joint arthritis**
			
			bssh.ac.uk fingersprains
			
			• Explanation of cause and
				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
				
				- replacing OP
				- OA
				- Loss of ADLS
					1 Listed for surgery based on i.e.:
					
					• Pain
					• Condition limiting function
					• Procedure dependent upon exact diagnosis
					• Patient wants and is fit for surgery
					
					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 advise (including exercise)
					• Hand Therapy at 1-2/52
					
					Aseptic Area - dependant on procedure
					Post Anaesthetic facility

	- photosensitive rash
	- significant alopecia
	- recurrent miscarriage
	
	Management (including condition-specific self-care options):
	
	• Course of analgesia and / or NSAIDs for a minimum of 2 - 3 weeks in line with agreed formularies / guidance
	• Review for resolution of symptoms
	• Monitor subjectively in line with ADLs
	• Condition specific Patient Information Leaflet should be given to the patient - **bssh.ac.uk finger joint arthritis**
	
	bssh.ac.uk fingersprains
			prognosis
			• Explanation of approaches to treatment
			• Analgesia advice
			• Advice on joint protection
			• Advice on mobilisation but not overuse as appropriate
			• Postural advice dependent on occupations and resulting Activities of daily living
			• Consider review by Hand Surgeon if:
			  • surgical intervention indicated
			  • Patient wants and needs surgery - fitness for surgery, pre-operative assessment, and discharge planning undertaken
			• Consider review by Hand Therapy:
			  • If indicated
			  • Patient does not want injection or surgery
			• Consider review by Rheumatology OT for:
			  • joint protection advice
			  • ADL assessment
			  • Splints
			  • Exercise
			  • Adaptive equipment if patient does not want surgery or injection / not suitable for injection
			
			4. Outcome tools
			
			• EQ5D
			• SURE
			
			HUB OR SPOKE ENVIRONMENT WITH MDT SPACE (2 rooms)		

Hand and Wrist group 19th December 2013

Peter Devlin (GP, BICS)
Bertie Brincat (ESP Hand Therapist, BICS / SCT)
Sarah Bell (ESP Physiotherapist, SCT)
Paul Forsdick (GP)
Ian Francis (Consultant Radiologist, MIP)
Helen Kuhn (Occupational Therapist, WSHT)
Miguel Oliveria (Orthopaedic Consultant, WSHT)
Matthew Carr (Service Manager, Horder Healthcare)
James Nicholl (Orthopaedic Consultant, Horder Healthcare / MTW)

Hand and Wrist group 17th July 2014

Peter Devlin (BICS, Clinical Director)
Bertie Brincat (BICS/SCT, Hand Therapist)
Di Finney (BICS, Consultant Rheumatology Nurse)
Natalie Blunt (BICS, Service Manager)
Kasia Kaczmarek (BICS, MSK Integrated Care Manager)
Sarah Bell (SCT, ESP)
Ian Francis (MIP, Consultant Radiologist)
Jane Vince (Horder Healthcare Service Manager)
Anita Vincent (Service Manager, SASH)
Liz Green (GP, B&H CCG)
James Blair (QVH, Consultant Plastic Surgeon)
Lisa Tourett (BSUH, Orthopaedic Consultant)
Sally Dando (SASH, Head of Therapies)
Kathryn Pank (QVH, Clinical Specialist)
Issy Heppenstall (ESP, SASH)
Laura Finucane (SCT, Consultant Physiotherapist)

(*total email distribution list (Natalie Blunt, Bertie Brincat, Peter Devlin, Liz Green, Di Finney, Ian Francis, Iben Altman, James Blair, John Bush, Kathryn Pank, Laura Finucane, Lisa Tourett, Lucy Hague, Matthew Carr, Murali Bhat, Paul Forsdick, Paul Gable, Rachel Dixon, Richard Bell, Sally Dando, Sarah Bell, Anita Vince, Jenny Whales, Jo Richardson, Jude Benharoch, Natasha Cracknell, Penny Bolton, Simon Oates, Fiona Howells, Jennifer Mantle, Sue Golby, Kasia Kaczmarek)*