Exclusions - East Sussex Outline Service Requirement document v 2.0 JUNE 2014:

- Intermediate Care
- Rehabilitation provided by the Joint Community Rehabilitation Service;
- Substance Misuse Services – although a close relationship would be expected between the MSK Service and Adult Social Care
- Children (aged 16 and under)
- Systemic rheumatological conditions – excluding rheumatoid arthritis
- Presentation relating to fractures sustained or procedures undertaken less than 6 months ago
- Patients with the following conditions will be excluded from the service:
    - Immediate life threatening conditions;
    - Suspected cancers and 2 week rule;
    - Acute trauma, e.g. RTA or falls from a significant height, still in the acute phase;
    - Non-mechanical pain: constant, progressive, not related to posture/activity;
    - 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;
    - Post-fracture patients;
    - Fracture Liaison services - both primary and secondary care
    - Neurophysiotherapy Rehabilitation
    - Complex hand surgery where the procedure comes under Specialised Commissioning HRG
    - Patients needing A&E
    - PbR excluded drugs

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

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

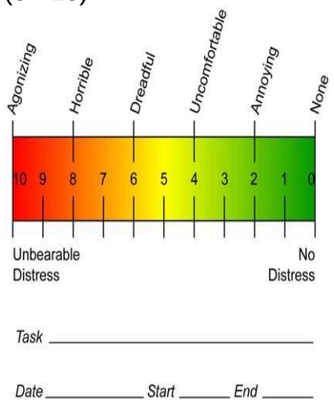
- The Federation of Disabled People - **http://www.thefedonline.org.uk/** and telephone **01273 296747**
  - advice, information and support; sign-posting; social prescribing; Direct Payments and Personal Budgets support; peer support; Get Involved Group

- 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
Muscular / General aches and pains ***No evidence of Inflammatory Arthritis*** *This group of patients represent a large group of patients with non-specific pain symptoms, without a clear diagnosis*[1]	**Examination, History & Assessment:** • Duration of pain • Rate and frequency of deterioration and symptoms • Pain level – Visual Analogue Score may be helpful (0 - 10)  • PMH/Co-morbidities/Peri-menopausal • Function: ADLs • Organ specific symptoms to exclude: systemic disease, depression, Anxiety, PHQ9 and GAD7 may be helpful • Non-specific weight-loss, fevers, sweats, fatigue, can't sleep, concentration, mood • Yellow flags (psycho-social): Work, relationships, leisure, QOL **Investigations:** Consider the following if symptoms are persistent and severe: • Urine dipstick – to investigate renal disease /	**Refer to Integrated MSK Service (Nurse Consultant / GPwSI / Consultant / Consultant Physiotherapist)** • No evidence of synovitis • All investigations normal ***or*** abnormal ESR (over 35 if patient is under the age of 40) ***or*** CRP is over 5 and all other tests normal • Persistent symptoms not responding to primary care management (more than 6 – 12 weeks) ***or*** marked deterioration in ADLs ***or*** severity of pain – Visual Analogue Score equal to or greater than 7 **Treat or refer to appropriate speciality** for all other abnormal investigations	**1 Patient education and information** **2 Assessment and Examination** • Review holistic assessment and check for red flags **3 Investigations** Consider the following if: • Urine dipstick – to investigate renal disease / involvement • FBC, U&E, LFT, random glucose, thyroid function, CRP/ESR, bone profile • Anti CCP if appropriate • Chest x-ray **4 Management** • Patient education • Medication management • Signs or symptoms of Inflammatory Arthritis – patient review by Consultant Rheumatologist **Rule out red flags** • Consider differential diagnoses **Chronic / Wide Spread Pain** • Pain Management / Medicine **Chronic Fatigue Syndrome** • For pain – Pain Management • For fatigue – refer to Chronic Fatigue Syndrome service / clinic **Fibromyalgia**	**N/A**	**N/A**

1

	involvement • FBC, U&E, LFT, random glucose, thyroid function, CRP/ESR, bone profile, CK, PSA 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 • Photosensitive rash • Significant alopecia • Recurrent miscarriage Consider myeloma screen if ESR is more than 35 (in patient under the age of 40) or CRP is raised – protein electrophoresis and urinary Bence Jones screen **Management (including condition-specific self-care options):** Generally expectant and supportive, review as necessary. At each review, check and re-check for: • Inflammatory joint pain (new) • More than 30 minutes stiffness in early morning • Signs of synovitis in hands, wrists or other painful joints • Consider the Squeeze Test – squeeze patient's hand / foot across the knuckle. If the test is unduly painful then it raises the suspicion of inflammatory arthritis If all tests are ok: • Patient education and advice • Simple analgesics in line with agreed formularies / NICE		See fibromyalgia pathway **Polymyalgia** See polymyalgia pathway **Joint Hypermobility Syndrome** See Joint Hypermobility pathway **5 Outcome tools** • Pain VAS • Functional ability SF36 • EQ5D • SURE **HUB OR SPOKE ENVIRONMENT POSSIBLE AS LONG AS 1) XRAY ACCESSIBLE AND 2) SPACE FOR MDT CLINICS (2 ROOMS)**		

	guidance • Psycho-social support • Consider vitamin D supplementation – for insufficiency (25OHD <30nmol/L), or sub-optimal (25OHD 30-50nml/L) and one or more of the following risk factors: ○ fragility fracture, documented osteoporosis or high fracture risk ○ treatment with anti-resorptive medication for bone disease ○ symptoms suggestive of vitamin D deficiency ○ increased risk of developing vitamin D deficiency in the future because of reduced exposure to sunlight, religious/cultural dress code, dark skin, etc ○ raised PTH ○ medication with antiepileptic drugs or oral glucocorticoids ○ conditions associated with malabsorption In these patients give 800 – 2000 IU daily (Desunin or Fultium-D3, both 1 tablet = 800IU of cholecalciferol, vitamin D3) Step-wise approach to analgesia (normal analgesic ladder <u>but avoiding NSAIDS and strong opioids</u>) http://www.britishpainsociety.org/book_opioid • Monitor response: Pain level – consider Visual Analogue Score, PHQ9, GAD7 and Activities of Daily Living				

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
Polymyalgia Rheumatica / Suspected Polymyalgia *The therapeutic goals are to control painful myalgia, to improve muscle stiffness, and to resolve constitutional features of the disease* *BSR 2011* *Follow the British Society of Rheumatology Guidelines*	**Examination, History & Assessment:** • Previous medical history • Systemic symptoms (non-specific weight-loss, fevers, sweats, fatigue, can't sleep, concentration, mood) • Symmetrical pelvic girdle and shoulder - proximal muscle pain • Early morning stiffness (muscular) • Headaches or visual (acute onset or new) • Check shoulder and hip movements • Check for shoulder capsulitis and neck movements • Synovitis – hot swollen tender joints **Investigations:** • Initially ESR, CK, CRP, PSA Further review as necessary: • LFT, kidney function, thyroid function,full blood count, bone profile, PA chest x-ray **Management (including condition-specific self-care options):** • Patient education and information **If ESR is 30 – 40:** Use clinical judgement -	**Refer as emergency to secondary care if Giant Cell Arteritis is suspected** • If headaches or temporal artery tenderness (acute onset or new), contact duty Consultant in Acute Medical Unit • If visual problems, contact duty Ophthalmology Team NB patients at highest risk of neuro-ophthalmic complications do not always mount high inflammatory responses **Refer to Integrated MSK Service (Consultant Rheumatologist)** **Pathway Note: MDT to review triage to clinician options** if no response to prescribed prednisolone after 1 week (as above), or signs or symptoms of Inflammatory Arthritis **Triage to Secondary Care CTDC (Connective** Tissue Clinic) if CK elevated over 2000	**1 Patient education and information** **2 Assessment and Examination (GPwSI, Nurse Consultant, Consultant / Consultant Physiotherapist, Consultant Rheumatologist)** • Review holistic assessment and check for red flags **3 Investigations** • Consider baseline bloods • LFTs, kidney functions, PSA • Chest X-Ray – AA Chest • CCP/Rheumatoid factor • Anti Nuclear Antibody (if appropriate) • Myeloma screen (if appropriate) • Urine dipstick **4 Management** • Review prednisolone levels and optimise as appropriate • Monitoring blood tests - ESR CRP to guide treatment along with clinical response • Consider Specialist OT / Rheumatology OT (depending on local arrangements) input • Review monthly for 3 months then 3 - 6 monthly depending on response	**Refer as emergency if Giant Cell Arteritis is suspected** • If headaches or temporal artery tenderness (acute onset or new), contact duty Consultant in Acute Medical Unit / Early Access GCA Clinic • If visual problems, contact duty Ophthalmology Team	**N/A**

	prescribe 15mg of prednisolone daily for 1 week then review: - If symptoms cease, follow PMR pathway below **If ESR is more than 40 and no synovitis, or GCA signs follow this PMR pathway:** Prescribe 15mg of prednisolone daily for 1 week and review. Enteric coated prednisolone should not be used. - If response is good then reduce dose slowly every 8 weeks aiming at 7.5mg daily at 6 months. (Eg 15mg – 13/12mg alternate days – 10mg – 9mg – 8mg – 7.5mg etc) - Provide Steroid Card with information - Glucocorticoid treatment may be required for 18-24 months - Relapses on dose reduction can be treated with an increase to the last effective dose **Risk Assessment** NICE recommend a fracture risk assessment on a dose of 5mg or above for those likely to be taking corticosteroids for three months or longer, especially in post- menopausal women. Those aged 65 or over are at greater risk. www.shef.ac.uk/**FRAX**/tool.jsp Patients taking a dose of 5mg or above of oral corticosteroids who have sustained a low-trauma fracture should receive treatment for osteoporosis. The therapeutic options for prophylaxis and treatment of		and review for signs of synovitis • Shared care arrangement with GP • If PMR is unresponsive, or synovitis evident – patient review by Consultant Rheumatologist **5 Outcome Tools** • Pain assessment • Functional ability – SF36 • EQ5D • DAS28 • SURE **HUB OR SPOKE ENVIRONMENT POSSIBLE AS LONG AS 1) XRAY ACCESSIBLE and 2) MDT CLINIC SPACE (2-3 ROOMS)**		

	corticosteroid-induced osteoporosis are the same. As per NICE TA160 and TA161, consider bisphosphonates with calcium and vitamin D supplementation.				
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**
Fibromyalgia *A definite diagnosis can lead to more focused and successful treatment and reducing the stress of the unknown.* *Optimal management requires a comprehensive bio-psychosocial approach with a strong, consistent, trusting and long-term clinician–patient relationship.* *ACR Diagnostic Criteria 1990* ***www.rheumatology.org*** *Hands on: 'Fibromyalgia Syndrome: Management in Primary Care'* ***http://www.arthritisresearchuk.org***	**Examination, History & Assessment:** • Duration of pain • Rate and frequency of deterioration and symptoms • Pain level – Visual Analogue Score (0 -10) may be helpful • PMH/Comorbidities/Peri-menopausal • Function: ADL's • Organ specific symptoms to exclude: systemic disease, depression, Anxiety, PHQ9 GAD7 may be helpful • Non-specific weight-loss, fevers, sweats, fatigue, can't sleep, concentration, mood • Yellow flags (psycho-social): Work, relationships, leisure, QOL • Requires full examination including lymph nodes, breasts and thyroid **Investigations:** Consider the following if symptoms are persistent and severe: • Urine dipstick – to investigate renal disease / involvement • FBC, U&E, LFT, random glucose, thyroid function, CRP/ESR, bone profile, PSA • CK, chest x-ray **Management (including condition-specific self-care**	**Refer to Integrated MSK Service (Nurse Consultant / Consultant Physiotherapist)** • No evidence of synovitis • All investigations normal ***or*** abnormal ESR (over 35) or CRP over 5 all other tests normal • Persistent symptoms not responding to primary care management (more than 6 – 12 weeks) ***or*** marked deterioration in ADLs ***or*** severity of pain – Visual Analogue Score equal to or greater than 7 • If diagnostic difficulty **Refer to Integrated MSK Service (Specialist OT / Rheumatology OT/ Physiotherapist) for specific concerns regarding symptom management** **Treat or refer to appropriate speciality** for all other abnormal investigations **Refer to Integrated MSK Service (Rheumatologist)** If diagnostic uncertainty and raised ANA	**1 Patient education and information** **2 Assessment and Examination (Nurse Consultant / Consultant Physiotherapist)** • Review holistic assessment and check for red flags **3 Investigations** Consider the following if symptoms are persistent and severe: • Urine dipstick – to investigate renal disease / involvement • FBC, U&E, LFT, random glucose, thyroid function, CRP/ESR, bone profile, PSA • Anti CCP if appropriate **4 Management** • Patient education • Medications management • 1:1 session / CBT • Self-management programme or Pain management programme • Top up group • Liaise with GP • Symptom management provided by the MDT including Specialist OT / Rheumatology OT / Physiotherapist		

	options): Generally expectant and supportive, review as necessary. At each review, check and re-check for: • Inflammatory joint pain (new) • More than 30 minutes stiffness in early morning If all tests are ok: • Patient education and advice • Simple analgesics in line with agreed formularies / NICE guidance • Psycho-social support • Consider vitamin D supplementation – for insufficiency (25OHD <30nmol/L), or sub-optimal (25OHD 30-50nml/L) and one or more of the following risk factors: ○ fragility fracture, documented osteoporosis or high fracture risk ○ treatment with anti-resorptive medication for bone disease ○ symptoms suggestive of vitamin D deficiency ○ increased risk of developing vitamin D deficiency in the future because of reduced exposure to sunlight, religious/cultural dress code, dark skin, etc ○ raised PTH ○ medication with antiepileptic drugs or oral glucocorticoids ○ conditions associated with malabsorption In these patients give 800 – 2000		• Pain management team support • Pain toolkit **5 Outcome Tools** • FIQ • SF 36 • VAS pain • GAD 7 • PHQ9 • EQ5D • SURE **SPOKE ENVIRONMENT AS NO ACCESS TO IMAGING REQUIRED AND ACCESS FOR MDT CLINIC SPACE (2 ROOMS)**		

	IU daily (Desunin or Fultium-D3, both 1 tablet = 800IU of cholecalciferol, vitamin D3) *[Ref: Vitamin D and Bone Health: A Practical Clinical Guideline for Patient Management; National Osteoporosis Society, April 2013]* • Step-wise approach to analgesia (normal analgesic ladder <u>but avoiding NSAIDS and strong opioids</u>) – If stepping up to opiates there is some evidence that Tramadol may be particularly effective (EULAR) • Monitor response: Pain level Consider: Visual Analogue Score, PHQ9, GAD7 and ADLs • SSRIs, usually citalopram or sertraline • Low dose amitriptyline or nortriptyline, and second line gabapentin				
Referral reason / Patient presentation	**Primary Care Management**	**Thresholds for Primary Care to initiate a referral to Integrated MSK Service**	**Management Pathway for the Integrated MSK Service**	**Thresholds for referral to Specialist In-patient Care**	**Management Pathway for Specialist In-patient care**
Inflammatory Mono-arthritis *NICE RA 2009 guidelines recommend early diagnosis and treatment in order to increase the likelihood of achieving disease remission* ***Awareness raising regarding patients flagging up their symptoms to their GP at an early stage is key***	**Examination, History & Assessment:** • Acute phase: rapid onset; often at night or early morning • 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)	**Refer to A&E if septic arthritis suspected** **Urgent referral to Integrated MSK Service (Consultant Rheumatologist / GPwSI / Consultant Nurse / Consultant Physiotherapist)** if first episode **and** symptoms are more than 10 days **and** not responding to primary care **Referral to Integrated MSK**	**1 Patient education and information** **2 Assessment and Examination (Consultant Rheumatologist / GPwSI / Consultant Nurse, Consultant Physiotherapist)** • Review referral information including history and investigation results **3 Investigations** • Consider imaging (depending on joint affected) – i.e. X-ray,	**Refer to A&E if septic arthritis suspected** **Pathway for repeat referrals into orthopaedics via A&E needs defining**	

	• Single or several joint pain or swelling; small / large joints involved and distribution • Rule out red flags and systemic symptoms (i.e. rashes) • Risk factors; beer or spirits, male, thiazide diuretics, renal disease, insulin resistance, metabolic syndrome, high BMI, high alcohol intake, steroids etc • Consider differential diagnosis such as Gout, Septic arthritis, osteoarthritis, pseudo-gout reactive arthritis, therefor check for enthesitis, STI, IBD, Iritis • Family history / onset within last 12 months **Investigations:** • Full blood count, uric acid (if normal,) U&E, CRP, ESR, Rheumatoid factor • Patient temperature • **No imaging necessary** (acute onset) **<u>Note:</u> A urate level within the normal range does not exclude a diagnosis of gout** 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 • Photosensitive rash • Significant alopecia • Recurrent miscarriage **Management (including condition-specific self-care options):**	**Service (Specialist OT / Physiotherapist / Hand Therapist) for specific functional issues**	Ultrasound • CCP antibodies • Consider an MR **4 Management** • Discuss management plan options with patient Dependent upon diagnosis consider: • Patient information • Analgesia in line with agreed formularies / NICE guidance • Joint aspiration • Joint injection • Image guided injection • Functional interventions i.e. wrist splints • Symptom management provided by the MDT including Specialist OT / Rheumatology OT / Physiotherapist Medication management **5 Outcome tools** • Pain score / measurement • EQ5D • SURE **HUB ENVIRONMENT AS XRAY / ULTRASOUND NEEDED AND MDT CLINIC SPACE REQUIRED (3 – 4 ROOMS)**		

	If gout suspected go to gout pathway • Patient education, lifestyle moderation • Use of ice packs (RICE) • Stop or change precipitating drug where appropriate to do so • NSAID risk assessment GI / CV / Renal • Naproxen 750mg then 250mg every 8 hours with PPI				
Referral reason / Patient presentation	**Primary Care Management**	**Thresholds for Primary Care to initiate a referral to Integrated MSK Service**	**Management Pathway for the Integrated MSK Service**	**Thresholds for referral to Specialist In-patient Care**	**Management Pathway for Specialist In-patient care**
Inflammatory Poly-arthritis New onset or suspected *NICE RA 2009 guidelines recommend early diagnosis and treatment in order to increase the likelihood of achieving disease remission* ***Awareness raising regarding patients flagging up their symptoms to their GP at an early stage is key***	**Examination, History & Assessment:** • Two or more painful joints • Early morning stiffness for 30 minutes (often diurnal) • Duration is more than 3 - 4 weeks • Single or several joint pain small / large joints involved and swelling in hands and feet	**Urgent referral to Integrated MSK Service within 3 days (Consultant Rheumatologist, GPwSI / Consultant Nurse / Consultant Physiotherapist)** **<u>Note:</u> Integrated MSK Service Rheumatology MDT Triagers to discuss with referring GP re initiating patient on oral steroids / IM depo prior to first appointment**	**1 Patient education and information** **2 Assessment and Examination (Consultant Rheumatologist / GPwSI / Consultant Nurse / Consultant Physiotherapist)** • Review referral information including history and investigation results **3 Investigations** • Consider imaging (depending		

	• Fatigue, sleep pattern • Rule out red flags and systemic symptoms i.e. rashes, fever, risk factors family history, smoking • Consider differential diagnoses **Investigations** • Full blood count, ESR / CRP, renal, liver, bone profile, rheumatoid factor, PSA • Cardiovascular risk factors Auto-antibodies tests are unlikely to be helpful, unless suspected connective tissue disorder such as: • dry eyes • dry mouth • photosensitive rash • significant alopecia • recurrent miscarriage **Management (including condition-specific self-care options):** • Patient education and advice • Step-wise approach to analgesia (normal analgesic ladder <u>but avoiding NSAIDS and strong opioids</u>) • Start oral steroids after discussion with MSK Integrated Service Rheumatology MDT		on joints affected) – i.e. X-ray, Ultrasound • MRI (NB USS is good for synovitis MRI good for early erosive change in bone and to check response) Pathway Note: Consider AIP? Ask Dr Jordan if that's what she meant? **4 Management** • Discuss management plan options with patient Dependent upon diagnosis consider: • Patient information • Peer support groups • Psychological support • Analgesia in line with agreed formularies / NICE guidance • Joint aspiration • Joint injection • Image guided injection • Functional interventions i.e. wrist splints • Symptom management provided by the MDT including Specialist OT / Rheumatology OT / Physiotherapist • Initiate DMARDS and review monthly ○ Once stable after 3 – 6 months initiate Shared Care Protocol with GP ○ After 12 months follow Established Inflammatory Arthritis pathway • Biologics treatment – • Assessment and management • Liaison with home care company • Education • infusions undertaken		

			as day case NB also ensure guidelines cover swapping to subcut preparations as they become available. Consider if any must be done in secondary care eg those who have had a reaction **5 Outcome tools** • Pain score / measurement • EQ5D • PHQ9 • DAS28 • SURE **HUB ENVIRONMENT AS XRAY / USS NEEDED AND MDT CLINIC SPACE REQUIRED (3 – 4 ROOMS)** **1 single Hub identified for the day case infusion treatment**		
Referral reason / Patient presentation	**Primary Care Management**	**Thresholds for Primary Care to initiate a referral to Integrated MSK Service**	**Management Pathway for the Integrated MSK Service**	**Thresholds for referral to Specialist In-patient Care**	**Management Pathway for Specialist In-patient care**
Gout *The spectrum of the disease is broad. Management tends to be considered in two separate phases* ***Acute:*** *Aim to provide rapid relief of*	**Examination and History:** • Acute phase: rapid onset; often at night or early morning • Severe pain reaching its peak in less than 24 hours • Swelling and erythema • 1st Metatarso Phalangeal	**Refer to A&E if septic arthritis suspected** **Refer to Integrated MSK Service (Nurse Consultant / GPwSI / Consultant Rheumatologist / Consultant Physiotherapist)** if: • unresponsive or toxicity to allopurinol	**1 Patient education and information** • Lifestyle factors • Medication **2 Assessment and Examination (Nurse Consultant / GPwSI / Consultant Rheumatologist / Consultant Physiotherapist)**	**Refer to A&E if septic arthritis suspected**	

joint pain and inflammation ***Chronic:*** *Aim to use urate* *Consider role of MSK podiatry*	– 90% • In 70% the first joint is affected • Risk factors; beer or spirits, male, thiazide diuretics, renal disease, insulin resistance, metabolic syndrome • Consider differential diagnosis such as septic arthritis, osteoarthritis • Joint aspiration can be considered *'when the diagnosis is uncertain, as even though it is considered the gold standard for confirming gout, aspirating an acutely inflamed joint is unnecessary when the diagnosis can be made clinically'* (Map of Medicine) **Investigations:** • Urate levels (repeat once attack resolves if normal), ESR, CRP, U&E rheumatoid factor, FBC **<u>Note:</u> A urate level within the normal range does not exclude a diagnosis of gout** • **Note** hyperuriceamia is common and does not equate to gout unless there is a typical presentation • Aspirate for crystal examination, if possible: culture and gram stain • Patient temperature • No imaging necessary 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	• first episode **and** symptoms are more than 10 days **and** not responding to primary care management **Refer to a Consultant Urologist** if patient has urolothiasis	• Holistic assessment and check for red flags **3 Investigations** • Urate levels (repeat once attack resolves if normal), ESR, CRP, U&E rheumatoid factor, FBC • Aspirate for crystal examination, if possible: culture and gram stain **4 Management** • If allopurinol toxicity consider febuxostat (NICE 2008) or sulfinpyrazone if renal function normal • Agree management plan with patient • Caution with renal impairment • **Patients with urolithiasis should be assessed by a Consultant Urologist** • If chronic gout, refer to Podiatry • Shared care arrangement with GP • Patient review by Consultant Rheumatologist if: • Intolerance of allopurinol, febuxostat sulphinpyrazone • Uncontrolled recurrent attacks when serum urate is less than 0.3mmol/L • Acute gout attack that fails to resolve within 14 days when treated as above. • Uncontrolled recurrent gout attacks despite use of allopurinol, febuxostat or sulphinpyrazone **5 Outcome Tools** • Pain Visual Analogue Score • Functional ability SF36 • EQ5D		

	• dry mouth • photosensitive rash • significant alopecia • recurrent miscarriage **Management (including condition-specific self-care options):** • Patient education, lifestyle moderation • Use of ice packs (RICE) • Stop or change precipitating drug where appropriate to do so • NSAID eg naproxen 750mg then 250mg every 8 hours with PPI • Colchicine 0.5mg 2 - 4 times daily • Continue for 48 hours after attack has passed • Systemic steroids eg 20mg daily for ○ 5 days if NSAID or colchicine are not tolerated • Review at 4 - 6 weeks to assess lifestyle factors, BP serum urate, renal function blood glucose and cholesterol • Monitor response: Pain level, Visual Analogue Score **Chronic Disease Management:** • Lifestyle factors • Agree management plan with patient • Caution with renal impairment • First line treatment with allopurinol 1-2 weeks after inflammation has settled, and uptitration • NSAID or colchicine prophylaxis for at least one month of starting urate lowering therapy • If acute attack develops during treatment this should be treated in its own right		• SURE **SPOKE ENVIRONMENT AS MDT CLINIC SPACE REQUIRED ONLY (1 - 2 ROOMS)** *Pathway note:* *Dr Jordan is reviewing this pathway and updating it which would hopefully fulfil concerns about the over simplification of this section, which Dr Jordan was one of the originators anyway so important to have her input DF*		

Referral reason / Patient presentation	Primary Care Management	Thresholds for Primary Care to initiate a referral to Integrated MSK Service	Management Pathway for the Integrated MSK Service	Thresholds for referral to Specialist In-patient Care	Management Pathway for Specialist In-patient care
Established Inflammatory Arthritis *(Long-Term Conditions Strategy)*	**Examination and History:** • Review diagnosis and existing care plan • Two or more painful joints	**Refer to Integrated MSK Service (~~GPwSI~~ / Nurse Consultant / Nurse Specialist)** • for all follow-ups	**1 Patient education and information** • 1:1 clinic follow up • Education groups –	**N/A**	**N/A**

i.e. Patients with an established Inflammatory Arthritis diagnosis, chronic flare-ups *After initial assessment and treatment in secondary care, suitable patients on disease modifying anti rheumatic drugs (DMARDS) will be monitored in the MSK ICATS, utilising a shared care approach to treatment with GPs and Secondary care in partnership* *Patients will be provided with education, rapid access and MDT intervention as needed* *NICE RA Guidelines 2009*	• Early morning stiffness for 30 minutes (often diurnal) • Duration is more than 6 weeks • Single or several joint pain small / large joints involved and swelling in hands and feet • Fatigue, Visual Analogue Scale pain score may be helpful, sleep pattern • Rule out red flags and systemic symptoms i.e rashes, fever, risk factors family history, smoking • History of previous and current management • Check patient knowledge of disease **Management (including condition-specific self-care options):** • Patient education and advice • Shared Care Protocol DMARD management • Review analgesia • Consider IM depomedrone for flares but also alert Integrated MSK Service	• for flares (rapid access) or review of DMARDS • for assessment for self-management programme	including self-management strategies • Advice line information • Resource materials **2 Assessment and Examination (GPwSI / Nurse Consultant / Nurse Specialist / Consultant)** • Disease activity monitoring • Musculoskeletal assessment • Holistic assessment including co-morbidities, functional ability and mood • Medication review • Cardiovascular risk factors • Anti TNF checklist (if required) **3 Investigations** As needed for routine monitoring or investigations as required • LFTs, U&E, FBC, TFT, ESR, CRP, Anti CCP and Rheumatoid Factor, AIP, PC3, GGT, PSA • X-rays as indicated • Ultrasound scan – hands, feet and spine • MRI • CT for patients with metal work) • DEXA scan **4 Management** • Agree management plan with patient • Ongoing review frequency according to need • Medication escalation and adjustment • Medication changes • Soft tissue and joint injection • Specialist OT / Physiotherapist review if ADLs or hand functions are affected		

			• Patient review by Consultant Rheumatologist: – For Biologic therapy – New systemic features of disease – Named consultant for annual review appointment in place • Shared Care Protocol with GP • Monitoring of established Biologic drug **5 Outcome Tools** • Disease activity scores • PHQ9 • SF36 • RASE • EQ5D • SURE **6 Rehabilitation services provided by Specialist OT / Rheumatology OT / Physiotherapist / Hand Therapist** **HUB ENVIRONMENT AS XRAY / USS / MRI NEEDED AND MDT CLINIC SPACE REQUIRED (3 – 4 ROOMS)**		
Referral reason / Patient presentation	**Primary Care Management**	**Thresholds for Primary Care to initiate a referral to Integrated MSK Service**	**Management Pathway for the Integrated MSK Service**	**Thresholds for referral to Specialist In-patient Care**	**Management Pathway for Specialist In-patient care**
Generalised Osteoarthritis *Pain affecting multiple joints*	**Examination, History & Assessment:** • Age • History • Co-morbidities • Joint examination • Comprehensive psychosocial assessment • Consider differential diagnoses	**Refer to Integrated MSK Service (General Physiotherapy)** if flare ups are not settling, or patient does not want a surgical intervention **Refer to Integrated MSK Service (Nurse Consultant / Nurse Specialist / Consultant Physiotherapist)** for education group or 1:1 assessment if requested (e.g. if OA knee and	**1 Patient education and information** • 1:1 clinic follow up • Education groups – including self-management strategies • Advice line information • Resource materials **2 Assessment and Examination (General**	**Refer for joint surgery if indicated and patient wants surgery** **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**	

	Investigations: • Blood Pressure, Haemoglobin level, kidney function, EGFR, PSA **Management (including condition-specific self-care options):** • Patient education • ADL modifications • Step-wise approach to analgesia – follow the analgesic ladder (but avoiding NSAIDS) **NICE OA Advice - Core symptom- relieving therapies:** Access to appropriate information: • Offer accurate verbal and written information to enhance understanding of osteoarthritis and management of the condition • Offer advice on appropriate footwear (including shock-absorbing properties) for people with lower limb osteoarthritis Activity and Exercise: • Exercise should include local muscle strengthening and general aerobic fitness • Exercise should be a core treatment irrespective of age, co-morbidity, pain severity and disability Interventions to help weight-loss: • Offer to people with osteoarthritis who are overweight or obese	patient does not want surgery) **Refer to Integrated MSK Service (Consultant / GPwSI / Nurse Consultant)** for specific joints if night pain, reduced ADLs, failure to respond to analgesia for more than 3 months **and** patient is not requesting surgical intervention **Refer to Integrated MSK Service alternative pathway (as relevant)** if patient wants and needs joint surgery **Refer to Integrated MSK Service (General Physiotherapy)** **Refer to OT**	**Physiotherapist / GPwSI/Nurse Consultant / Nurse Specialist / Consultant / Consultant Physiotherapist)** • Musculoskeletal assessment • Holistic assessment including co-morbidities, functional ability and mood • Medication review • Cardiovascular risk factors **3 Management** • Agree a management plan with patient • Ongoing review frequency according to need • Medication review and adjustment • Joint injection, e.g. knees • Specialist OT / Rheumatology OT / Physiotherapist review if ADLs or hand functions are affected • Podiatry **4 Outcome Tools** • PHQ9 • EQ5D • Pain VAS • SURE **SPOKE ENVIRONMENT AS MDT CLINIC SPACE REQUIRED ONLY (2 – 3 ROOMS)**		
Referral reason / Patient presentation	**Primary Care Management**	**Thresholds for Primary Care to initiate a referral to**	**Management Pathway for the Integrated MSK Service**	**Thresholds for referral to Specialist In-patient Care**	**Management Pathway for Specialist In-patient care**

		Integrated MSK Service			
Osteoporosis **Refer to MoM National pathway** **Reference update?**	**Refer to MoM National pathway** **http://app.mapofmedicine.com/mom/32/pag e.html?department-id=4&specialty-id=1010&pathway-id=3079&page-id=7304&history=clear**	**Refer to Falls Prevention Service** if high risk **Refer to Integrated MSK Service (Consultant)** if strontium, raloxifene or IV bisphosphonate is not an option **and** an assessment for teriparatide or denosumab is required	**1 Patient education and information** **2 Assessment and examination (Consultant)** • History to assess possible risk factors for osteoporosis and secondary causes • Fracture history • Review general medical issues and any contribution to risk **3 Management** • Pain relief in line with agreed formularies / guidance • Assess need for bone specific therapy including DEXA and risk • Management of on-going high cost drug therapies • Physiotherapy • Occupational Therapy • Falls Service • Specialist Nurse • Brace • Rehabilitation • Assessment of patients who might be suitable for vertebroplasty **4 Outcome Tools** • PHQ9 • SF36 • EQ5D • SURE **SPOKE ENVIRONMENT AS MDT CLINIC SPACE REQUIRED ONLY (1 ROOM)**		

Referral reason / Patient presentation	Primary Care Management	Thresholds for Primary Care to initiate a referral to Integrated MSK Service	Management Pathway for the Integrated MSK Service	Thresholds for referral to Specialist In-patient Care	Management Pathway for Specialist In-patient care
Joint Hypermobility Syndrome (JHS) / or suspected JHS *Joint Hypermobility Syndrome is a heritable disorder of connective tissue (HDCT) with clinical features that overlap with other HDCTs which must be excluded at the outset.* *The wider array of problems seriously impact quality of life.*	**Assessment:** • GPs can undertake Beighton and Brighton scores **Examination and History:** • Presence of Marfans syndrome or Ehlers Danlos Syndrome I, II, or IV **exclude** JHS • History of bone fragility, bruising, ocular problems, flat feet, tender trigger points • Absence of inflammatory arthritis • Lack of effectiveness of local anaesthetics • Functional assessment, Pain Visual Analogue Score may be helpful • Systemic symptoms • Yellow flags check – connective tissue disease, recurrent miscarriage **Investigations:** • ESR, CRP, • Bone density • Check for mitral regurgitation: listen to heart **Management (including condition-specific self-care options):** • Patient education / information • Analgesia using NSAIDS or simple analgesics short term (include risk assessment and PPI cover)	**Refer to Integrated MSK Service (Nurse Consultant / GPwSI)** if there is no demonstrable systemic inflammatory disease **Refer to Integrated MSK Service (General Physiotherapy)** for specific MSK reasons **Refer to Integrated MSK Service (Pain)** for pain management **Refer to appropriate specialty** if Marfanoid habitus together with cardiovascular or ocular involvement	**1 Patient education and information** **2 Assessment and examination (Consultant Nurse/ GPwSI / General Physio / Pain MDT)** **3 Investigations** Consider the following if not done • Urine dipstick – to investigate renal disease / involvement • FBC, U&E, LFT, random glucose, thyroid function, CRP/ESR, bone profile • Anti CCP if appropriate **4 Management** • Joint Hypermobility • Patient Education Group • Specialist OT / Rheumatology OT / Physiotherapist review if ADLs or hand functions are affected • Lifestyle modification • Exercise advice • Joint protection • Strengthening • Balance and proprioception training • Osteopathy advice **5 Outcome Tools** • SF36 • Pain Visual Analogue Score • EQ5D • SURE		

	Beighton Score **Scoring 1 point each side:** Passive Dorsiflexion 5th MCP 90° Apposition thumb to flexor aspect of forearm Hyperextension elbow beyond 0° Hyperextension knee beyond 0° **Scoring 1 point:** Forward flexion flat hands to floor with knees straight **Maximum score 9** **Brighton score** **Major criteria** Beighton score >4 (currently or historically Arthralgia for > 3 months in 4 or more joints **Minor criteria** Beighton score 1 – 3 (0 – 3 if > 50 years) Arthralgia or back pain > 3 months Spondylosis, spondylolysis / spondylolisthesis Dislocation / subluxation in one joint more than once or in more than one joint Soft tissue rheumatism ≥ 3 lesions Marfinoid habitus Thin skin, striae, hyperextensibilty, papyraceous scarring Droopy eye lids, myopia, or antimongoloid slant Varicose veins, hernia, uterine or rectal prolapse Diagnosis confirmed in presence of 2 major criteria ***or*** 1 major and 2 minor criteria ***or***		**SPOKE ENVIRONMENT AS MDT CLINIC SPACE REQUIRED ONLY (2 - 3 ROOMS)**		

	2 minor and 1st degree relative affected ***or*** 4 minor criteria				
Referral reason / Patient presentation	**Primary Care Management**	**Thresholds for Primary Care to initiate a referral to Integrated MSK Service**	**Management Pathway for the Integrated MSK Service**	**Thresholds for referral to Specialist In-patient Care**	**Management Pathway for Specialist In-patient care**
Suspected Connective Tissue Disorder (CTD) *Heterogeneous group of rare disorders but potentially life threatening.* *Occur in all ages but higher prevalence in young – middle aged adults and especially females.* *Wide spectrum of clinical manifestations of:* • *Arthritis / arthralgia* • *Myalgia* • *Muco-cutaneous* • *Renal* • *Pulmonary* • *Fever, malaise, fatigue, weight loss* *Requires high level of awareness and clinical suspicion*	**Assessment:** • Family history of CTD • Symptoms suggestive of CTD can include: ○ Raynaud's phenomenon – especially middle age onset ○ Arthralgia plus sun-sensitive rash ○ Dry eye / dry mouth with joint symptoms ○ Inflammatory muscle pain / weakness ○ Possible vasculitic rashes with joint pains ○ Respiratory problems ○ Fever, malaise, fatigue and weight loss **Investigations:** • FBC, ESR / CRP, RhF, auto-antibodies, U&Es, LFTs, urinalysis • Chest X-ray	**Refer to Integrated MSK Service (Consultant Rheumatologist)** if a CTD is suspected and positive inflammatory markers ***Note:* referral could also be to Respiratory / Renal / or other physician depending on symptom complex**	**1 Patient education and information** **2 Assessment and examination (Consultant Rheumatologist)** **3 Investigations** **4 Management** **5 Outcome Tools** • EQ5D • SURE **SPOKE ENVIRONMENT AS MDT CLINIC SPACE REQUIRED ONLY (2 - 3 ROOMS)**	**N/A**	**N/A**

Referral reason / Patient presentation	Primary Care Management	Thresholds for Primary Care to initiate a referral to Integrated MSK Service	Management Pathway for the Integrated MSK Service	Thresholds for referral to Specialist In-patient Care	Management Pathway for Specialist In-patient care
Established Connective Tissue Disorder Other potential diagnoses include any kind of suspect inflammatory disease (with a very wide range of presenting symptoms) and a wide ranges of diagnoses which include malignancy, sarcoid, psoriatic arthritis, reactive arthritis, ankylosing spondylitis, inflammatory aortitis, calcium crystal diseases, genetic disorders etc, etc The current list does not reflect this	**Management (including condition-specific self-care options):** • Supportive care planning and co-ordination of shared care • Management of co-morbidities and inter-current illness	**Refer to Integrated MSK Service** for ongoing shared care	**1 Patient education and information** **2 Assessment and examination (Consultant Rheumatologist)** **3 Investigations** **4 Management** **5 Outcome Tools** • EQ5D • SURE **SPOKE ENVIRONMENT AS MDT CLINIC SPACE REQUIRED ONLY (2 - 3 ROOMS)**	**N/A**	**N/A**

Attendees: 19th June 2014

BICS Service Manager - Natalie Blunt
BICS Clinical Director - Peter Devlin
BICS Integrated Care Manager - Kasia Kaczmarek
BICS/SCT Consultant Nurse - Di Finney
SCT ESP - Lynn Buckingham
SCT Director of Chiropody/Podiatry - Richard Bell
BSUH Consultant Rheumatologist - Kelsey Jordan
BSUH Director of Service Transformation - Sally Howard
BSUH Rheumatologist Specialist Nurse - Helen Smith
NHS Horsham and Mid Sussex CCG,GPSI - Meera Smethurst
Horder Healthcare, Clinical Director - Rachel Dixon
MIP Consultant Radiologist - Ian Francis
SASH Head Therapies - Sally Dando
SASH Service Manager - Victoria Bailey
SASH Service Manager - Charminia Fletcher