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
Shoulder Pain **Traumatic** ○ *Fractures* ○ *Dislocations (Gleno-humeral)* ○ *ACJ pain / dislocation* ○ *Rotator cuff tears* **Acute Trauma /A&E** Most missed RC tears diagnoses are from A&E ACJ Type I Strain Type II partial subluxation Important that there is education for GP's + A&E doctors, especially regarding	**Assessment:** ○ History ○ Examination ○ Working / differential diagnosis **Diagnostics:** ○ If significant injury – X-ray plain film AP & axillary **Management (including condition-specific self-care options):** ○ If no fracture assess for: ○ Acute cuff tear: loss of strength and function. Refer urgently to MSK service within 2/52. ○ Traumatic ACJ: Type I-II N/A Physio, Type III-IV Surgery. * Trial physio, if	**Refer to Integrated MSK Service (Extended Scope Practitioner) as an urgent appointment if:** ○ Suspected rotator cuff tear with significant weakness / loss of function – **Urgent** **Refer to Integrated MSK Service (General Physiotherapy) if:** ○ Symptoms persist > 4 weeks but strength / movement maintained, no suggestion of an RC tear. **Refer to Integrated MSK Service (Extended Scope Practitioner) if:**	**1. Assessment and examination (General Physiotherapist / Extended Scope Practitioner / Orthopaedic Consultant)** ○ History ○ Examination ○ Exclude instability, cuff tear or fracture **2. Diagnostics** ○ X-ray plain film AP and axillary ○ Ultrasound scan ○ MR (if acute or chronic) Urgent MR: Acute/Young group <70. **3. Management:** ***a. Impingement*** ○ Consider sub acromial	**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** ○ Arthroscopic stabilisation/open stabilisation	**Acute Rotator Cuff Tear** Surgery: mini open repair Arthroscopic repair. GA/Regional block, treated as a day case. Laminar Flow Direct listing: Opportunity to be explored further by MDT **Chronic Rotator Cuff Tear** - Arthroscopic repair - Open Repair - Tenotomy, debridement - Ballooning space in acromion space (as new procedure) ***c. ACJ pain*** - AC reconstruction / mini open technique

younger patients.	unsuccessful. ○ If no significant loss of function or strength consider: - Pain relief in line with agreed formularies / guidance - Patient education / exercise sheet - Reassurance - Activity modification - Advise if pain increases to come back to GP **Pathway note: GPS would welcome more information about the types of ACJ injury**	○ Severe pain since injury ○ Deteriorating or persisting symptoms ○ GH recurrent subluxation ○ Symptomatic ACJ dislocation / subluxation **Refer to Integrated MSK Service (Orthopaedic Consultant) if:** ○ Fracture / GH subluxation on x-ray ○ ACJ subluxation and full ROM / No Pain but cosmetic reason in a young patient.	injection ○ Consider review by Senior Physiotherapist (include if received physiotherapy previously) ***b. Traumatic capsulitis*** ○ X-ray prior to injection to rule out serious pathology ○ Guided/Unguided GH injection first time as required * This needs further discussion at an MDT. **c. *Acute rotator cuff tear*** ○ Consider review by Orthopaedic Consultant if on-going symptoms ***d. Chronic rotator cuff tear*** ○ Review by Orthopaedic Consultant if significant functional problems and pain ○ Anterior deltoid rehab ○ Physio ***e. ACJ pain*** ○ Reassure ○ Consider ACJ ○ Unguided (if unguided not possible then guided injection) ○ Consider review by Orthopaedic Consultant if injection fails or symptoms reoccur ***e. GHJ instability*** ○ Consider Physiotherapy ○ Consider review by Orthopaedic Consultant if non resolving / on-going symptoms despite comprehensive physiotherapy and the patient is considering surgery ○ Consider MR Arthrogram ○ Request MRA for SLAP		

			lesions – if MRA is positive: Arthroscopic stabilisation/open stabilisation **4. Outcome Tools:** ○ EQ5D ○ Oxford Shoulder Score ○ SURE ○ Oxford shoulder unstable score **Hub or Spoke as long as access to Xray / USS and room space for MDT (2 – 3 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**
Shoulder Pain non-traumatic ***Impingement*** *(and calcific tendonosis - treat as impingement)* *Needs MDT sign off:* - *X-Ray if >6/52 and unsuccessful physio/symptoms persist.* *Impingement and associated conditions*	**Assessment:** ○ History ○ Duration of symptoms ○ Examination ○ Painful arc ○ Passive range of movement maintained ○ Strength maintained ○ **Red Flag – consider referred pain and intra-thoracic causes of pain** **Diagnostics:** ○ If considering referral: Xray to include / exclude non bony pathology i.e. calcific tendonosis, subluxation of ACJ, clinically relevant OA ACJ **Management (including condition-specific self-care options):** ○ Pain relief in line with agreed formularies / guidance ○ Activity modification ○ Patient education and	**Refer to Integrated MSK Service (General Physiotherapy) if:** ○ No response to treatment after 6 weeks or limited improvement with an injection after 2 weeks ○ And, patient is keen to try physiotherapy **Refer to Integrated MSK Service (Extended Scope Practitioner) if:** ○ No response to physiotherapy or conservative treatment at > 3 months	**1. Patient information** **2. Assessment and Examination (General Physiotherapist / Extended Scope Practitioner):** ○ History ○ Examination ○ Impingement test ○ Exclusion of other pathologies ○ Working diagnosis **3. Diagnostics:** ○ X-ray (AP and outlet view) if not already done ○ Consider ultrasound if suspect a cuff diagnosis ○ Consider MRI if suspect a cuff diagnosis / to exclude other possible diagnosis **4. Management:** ○ Patient education and info ○ Exercise sheet ○ Pain relief in line with agreed formularies /	**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** ○ arthroscopic decompression.	**1 Listed for surgery based on i.e.:** • Pain • Condition limiting function • Intrusive symptoms present after all conservative management options have been tried or discussed • Patient wants and is fit for surgery • Decompression **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

	information ○ Exercise sheet ○ If pain persists and ADLs limited / affected (i.e. sleep, work, driving) consider sub-acromial injection		guidance ○ Consider sub-acromial injection ○ further physiotherapy (review previous treatment) ○ Consider a second injection ○ Consider review by Orthopaedic Consultant for arthroscopic decompression. **5. Outcome Tools:** ○ EQ5D ○ Oxford Shoulder Score ○ SURE **Hub or Spoke as long as access to Xray / USS and room space for MDT (2 – 3 rooms)**		• Medically stable • Provided with appropriate post-operative exercises **Lamina Flow Theatre / 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**
Shoulder Pain non-traumatic ***AC joint pain***	**Assessment:** ○ History ○ Examination ○ Focal tenderness across ACJ ○ Pain on cross arm adduction ○ Pain on end of range elevation **Diagnostics:** ○ X-ray plain film AP & axillary **Management (including condition-specific self-care options):** ○ Reassurance ○ Patient education and info ○ Pain relief in line with agreed formularies / guidance ○ Activity modification	**Refer to Integrated MSK Service (Extended Scope Practitioner) if:** ○ Symptoms persisting	**1. Patient information** **2. Assessment and Examination (General Physiotherapist / Extended Scope Practitioner):** ○ History ○ Examination <6/52 general physio examination. ○ ESP >6/52 Flare Up ○ ESP >6/52 and if physio unsuccessful **3. Management:** ○ ACJ injection + consider further physio ○ If the patient fails to respond to injection or the response is transient then consider review by Orthopaedic Consultant ○ Consider second guided/unguided injection	**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** ○ ?arthroscopic excision	**1 Listed for surgery based on i.e.:** • Pain • Condition limiting function • Symptoms present following conservative management • Patient fails to respond to injection / response is transient • 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:**

			4. Outcome Tools: ○ EQ5D ○ Oxford Shoulder Score ○ SURE **Spoke**		• 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**
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**
Shoulder Pain non-traumatic ***Cuff tear (degenerate)***	**Assessment:** ○ History ○ Examination ○ Muscle weakness ○ Weakness on muscle testing ○ Impingement signs ○ Crepitus **Diagnostics:** ○ Plain film X-Ray **Management (including condition-specific self-care options):** ○ Pain relief in line with agreed formularies / guidance	**Refer to Integrated MSK Service (General Physiotherapy) if:** ○ Patient has manageable pain and manageable loss of function **Refer to Integrated MSK Service (Extended Scope Practitioner) as if:** ○ Increased pain ○ Loss of function ○ No response to physiotherapy at 4 - 6 weeks	**1. Patient information** **2. Assessment and Examination (General Physiotherapist / Extended Scope Practitioner):** ○ History ○ Examination **3. Diagnostics:** ○ ultrasound scan / MR **4. Management:** If patient is not considering surgery consider: ○ Patient education and info ○ Exercise sheet ○ Sub acromial injection + consider a second injection ○ Physiotherapy +++ Consider review by Orthopaedic Consultant if: ○ imaging confirms tear and not responding to injection or physiotherapy ○ Not direct listing **5. Outcome Tools:** ○ EQ5D ○ Oxford Shoulder Score	**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** ○ ? RC repair / reverse shoulder anthroscopy (for degenerative RC)	**1 Listed for surgery based on i.e.:** • Pain • Condition limiting function • Ultrasound scan confirms tear and patient not responding to physiotherapy or injection • 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 exercises **Aseptic Area - dependant on procedure** **Post Anaesthetic facility**

			○ SURE **Hub or Spoke as long as access to Xray / USS and room space for MDT (2 – 3 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**
Shoulder Pain non-traumatic ***Frozen shoulder (adhesive capsulitis)***	**Assessment:** ○ History ○ Examination ○ Marked restriction on external rotation, > abduction, > internal rotation ○ Insidious onset (Note: common in diabetes) **Diagnostics:** ○ X-ray plain film AP and axillary if symptoms severe **Management (including condition-specific self-care options):** ○ Pain relief in line with agreed formularies / guidance for up to 2 weeks ○ Education about frozen shoulder pain: Pain dominant phase / Stiff dominant phase ○ Consider a gleno-humeral injection if severe and persistent. (only after X-Ray too exclude serious pathology)	**Refer to Integrated MSK Service (Extended Scope Practitioner) if:** ○ severe pain / not coping with symptoms at > 6 weeks from onset. **N.B.** Physiotherapy aggravates in early stages <6/52 - Self manage + self-management information available. >6/52 - If patient has debilitating pain 6-12 weeks depending on presentation/severity.	**1. Patient information** **2. Assessment and Examination (Extended Scope Practitioner):** ○ History ○ Examination **3. Management:** ○ Pain relief in line with agreed formularies / guidance ○ Patient education and info ○ Exercise sheet ○ Consider physiotherapy to dominant stiff phase to help stiffness ○ Blind or guided injection (gleno-humeral) – prior to injection X-ray to rule out serious pathology ○ If injection successful, follow up with Physiotherapy ○ If no response to injection consider: ○ review by Orthopaedic Consultant ○ ~~o~~ Value of Hydro-dilation to be discussed at MDT **4. Outcome Tools:** ○ EQ5D ○ Oxford Shoulder Score ○ SURE	**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.:** • Imaging by consultant radiologist • Capsules release/ last resort MUA * needs further MDT discussion • Pain • Condition limiting function • Symptoms present following conservative management • Patient fails to respond to injection / response is transient • 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 exercises

			Spoke		**Lamina Flow Theatre / 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**
Shoulder Pain non-traumatic ***Osteoarthritis*** **Also follow the Rheumatology pathway for Generalised Osteoarthritis**	**Assessment:** ○ Age ○ History ○ Co-morbidities ○ Examination ○ Painful active range of movement ○ Reduced passive range of movement ○ Morning stiffness ○ Crepitus in joint (“Crunching”) ○ Consider differential diagnosis **Diagnostics:** ○ X-ray plain film AP & axillary **Management (including condition-specific self-care options):** ○ Patient education ○ ADL modifications ○ Step-wise approach to analgesia – follow the analgesic ladder (but avoiding NSAIDS)	**Refer to Integrated MSK Service (General Physiotherapy) if:** Flare ups are not settling, or patient does not want a surgical intervention. Physio can escalate to ESP **Refer to Integrated MSK Service (Extended Scope Practitioner) if:** ○ If diagnosis unclear ○ Pain or loss of function persisting ○ For access to arthritis education group or 1:1 assessment if requested (e.g. if patient does not want surgery) **Refer to Integrated MSK Service (Orthopaedic Consultant) if:** ○ patient wants and needs surgery ○ patient unclear about surgical option ○ Established OA, has already had one arthroplasty and now wants the other shoulder done. ○ >70 and already has established OA Review with an ESP+Physio together if physio unsuccessful to give patient reassurance	**1. Patient information** **2. Assessment and Examination (General Physiotherapist / Extended Scope Practitioner / Orthopaedic Consultant):** ○ History ○ Examination **3. Management:** ○ Patient education and information ○ Medication review and adjustment ○ Exercises ○ Steroid Gleno-humeral injection only if not considering surgery and in significant pain; consider a second injection. ○ Physiotherapy For patients who want and need surgery: ○ Commence Enhanced Recovery Program **4. Outcome Tools:** ○ EQ5D ○ Oxford shoulder score ○ Pain VAS ○ SURE **Spoke**	**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:** ○ Washout ○ Total Joint Replacement ○ Hemi-arthroplasty ○ Direct listing to Consultant – possible National Joint Registry – commences 14/08/2014	**1 Listed for surgery based on i.e.:** • Pain • Condition limiting function • Intrusive symptoms present following conservative management options • 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 exercises **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
Shoulder Pain non-traumatic ***Habitual subluxation / instability***	**Management (including self-care condition-specific options):** ○ Patient education ○ Physiotherapy	**Refer to Integrated MSK Service (General Physiotherapy)** Refer all if bothered by symptoms	**1. Patient information** **2. Assessment and Examination (General Physiotherapist):** ○ History ○ Examination **3. Management:** ○ Physiotherapy ○ Assessment and explanation in ICATS **4. Outcome Tools:** ○ EQ5D ○ Oxford Shoulder Unstable Score ○ SURE **6. Diagnostics**: X-ray MR MRA **Spoke**	**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
Lateral / Medial Elbow Tendinopathy **(Tennis and Golfer's elbow)**	**Assessment:** ○ History ○ Examination and Assessment ○ Focal tenderness ○ Lateral – pain on resisted wrist extension ○ Medial – pain on resisted	**Follow the Spine pathway if cervical element suspected** **Refer to Integrated MSK Service (General Physiotherapist) if:** ○ symptoms > 6 weeks ○ no / poor resolution from	**1. Patient information** **2. Assessment and examination (General Physiotherapist / Extended Scope Practitioner)**	**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.:** • Persistent pain • Condition limiting function • Symptoms persist > 6 months • Patient wants and is fit for surgery

	wrist flexion ○ Full **passive** range of elbow movement **Diagnostics:** ○ None **Management (including condition-specific self-care options):** ○ Patient education (booklet) ○ Exercise sheet ○ Activity modification ○ Pain relief in line with agreed formularies / guidance ○ Tennis elbow strap (e.g. epi-clast) patients can purchase in pharmacies or online ○ **Avoid injection unless in severe pain** / cannot lift objects / unable to grip and ideally symptoms > 6 weeks ○ **Second Injection <u>only if</u>** more than 50% improvement with first injection **(<u>note:</u> more than 2 injections are not recommended)** ○ Patient education regarding injection treatment Pathway note: MDT to review role of GTN patches	injection **Refer to Integrated MSK Service (Extended Scope Practitioner) if:** ○ Relapse after second injection ○ No response to Physiotherapy ○ Diagnostic query	○ History ○ Examination ○ Confirm diagnosis **3. Diagnostics:** ○ X-ray to check for radio-capitellar arthritis **4. Management:** ○ Patient education and info ○ Further specialist exercises ○ Consider injection ○ Dry needling ○ Consider review by Orthopaedic Consultant if: ○ Symptoms persist > 6 months ○ for possible surgical management / intervention ○ Consider referral for shockwave therapy (NICE Guidelines *Extracorporeal shockwave lithotripsy for calcific tendonitis of the shoulder 2003*) **5. Outcome Tools:** ○ EQ5D ○ QuickDash ○ SURE **Hub or Spoke as long as access to Xray / USS and room space for MDT (2 – 3 rooms)**		**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**

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
Olecranon bursitis	**Assessment:** ○ History ○ Examination and Assessment **Diagnostics:** ○ None	○ If confirmed as gout tophus **– follow the Rheumatology pathway** **Refer to Integrated MSK Service (Orthopaedic Consultant) if:**	**N/A**	**N/A**	**N/A**

	Management (including condition-specific self-care options): ○ If evidence of infection – antibiotics and rest ○ If large and non-infected bursitis – aspirate ○ If aspiration is not effective then consider steroid injection	○ Non resolving or unconfirmed diagnosis ○ Consider 2WW referral according to guidelines			
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**
Ulnar neuropathy ***Painful at elbow***	**Assessment:** ○ History ○ Examination and Assessment ○ Working / differential diagnosis ○ Tenderness over ulnar nerve ○ Intrinsic muscle wasting ○ Sensory disturbance little / ring finger **Diagnostics:** ○ None **Management (including condition-specific self-care options):** ○ Patient education ○ Avoid flexion at night ○ Avoid local pressure	**Refer to Integrated MSK Service (Extended Scope Practitioner) if:** ○ Progression of intrusive symptoms ○ Fixed sensory loss – loss of two point discrimination at 3mm ○ Muscle wasting	**1. Patient information** **2. Assessment and examination (Extended Scope Practitioner)** ○ History ○ Examination ○ Confirm diagnosis **3. Diagnostics:** ○ Nerve conduction studies ○ X-ray elbow **4. Management:** ○ Physiotherapy ○ Consider review by Orthopaedic Consultant if symptoms persist **5. Outcome Tools:** ○ EQ5D ○ SURE **Hub or Spoke as long as access to Xray and room space for MDT (2 – 3 rooms)**	**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.:** • Persistent pain • Condition limiting function • Nerve conduction studies are positive to presenting condition • Symptoms persist following physiotherapy • 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 exercises **Lamina Flow Theatre / 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**
Biceps ruptures ***Long head (common)***	**Assessment:** ○ History ○ Examination and Assessment ○ Working / differential diagnosis ○ Biceps bulge – typical 'popeye' sign ○ Check rotator cuff to exclude injury **Diagnostics:** ○ **<u>None</u>** **Management (including condition-specific self-care options):** ○ Patient education and information ○ Long head of biceps - reassure if no pain or loss of function ○ If pain / impingement – **follow impingement pathway** ○ If suspected cuff tear – **follow cuff tear pathway**	**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**
Distal biceps (rare)	**None**	**If acute or evidence of rupture – refer to Integrated MSK Service (Orthopaedic Consultant)**			

Shoulder and Elbow group 19th December 2013

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Jahnich Hagen (Orthopaedic Consultant, MTW)

Jamie Buchanan (Orthopaedic Consultant, Horder Healthcare / ESHT)

Mark Austin (ESP Physiotherapist, SCT)

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Matthew Daly (ESP Physiotherapist, ESHT)

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Shoulder and Elbow group 29th July 2014

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