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 condition;
- Suspected cancers/2 week wait rule
- Children (aged 16 and under)
- 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
CAUDA EQUINA SYNDROME	**Taken from the Map of Medicine:** Symptoms suggestive of cauda equina syndrome (compression of the cauda equina). Back pain **plus** one or more of: o Change in sexual function – erectile dysfunction, problems with ejaculation, loss of vaginal sensation o loss of bowel control (faecal or flatus incontinence) and unexpected laxity of anal sphincter o loss of bladder control (urinary	**Immediate referral by telephone to Orthopaedics / Neurosurgery on call Registrar- (depending on local arrangements)**	**N/A** **If suspected CES on triage within the referral letter- contact on call Registrar and referring GP** **If suspected CES when patient presenting within the Integrated Service – clinician to contact on call Registrar via telephone (Orthopaedic or Neurosurgery- depending on local arrangements)**	**N/A**	**N/A**

	retention or incontinence) ○ saddle anaesthesia or paraesthesia (loss or change of perianal and perineal sensation) ○ severe or progressive neurological deficit in the lower extremities or gait disturbance				

Referral reason / Patient presentation	Primary Care Management	Thresholds for Primary Care to initiate a referral	Management Pathway for the Integrated MSK Service	Thresholds for referral to Hospital / In-patient care	Management pathway for Hospital / In-patient care
SUSPECTED SERIOUS PATHOLOGY					
Acute motor deficit ***e.g. painful foot drop or quads palsy***	**Investigation:** • History • Examination and Assessment • Provisional / working diagnosis(es) **Diagnostics / Imaging:** • **<u>None</u>** **Management (including condition-specific self-care options):** • Explanation of cause	**Refer to Integrated MSK Service (Extended Scope Practitioner / Consultant Physiotherapist)** **If painful foot drop - urgent referral to an Orthopaedic Consultant – appointment within 1 working day** **If quads pain / quads weakness – urgent to an Orthopaedic Consultant**	**1 Patient information** **2 Assessment and examination (Extended Scope Practitioner / Consultant Physiotherapist)** • If painful myotomal weakness and 3/5 or less on MRC scale - request urgent MRI scan within one stop shop / 24 hours **3 Investigations** • Review MRI scan report **4 Management** • Patient needs and wants surgery – fitness for surgery, pre-operative assessment, and discharge planning undertaken - refer to spinal/ Neurosurgery (depending on local arrangements) • Consider follow up appointment for further review **5 Outcome tools** • EQ5D • 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**	Surgical preference **Decompression:** • **Laminectomy** • **Discectomy** • **Microdiscectomy** **1 Listed for surgery based on i.e.:** **<u>Discectomy</u>** • Radicular leg pain • Sensory loss in dermatomal distribution • Pain • MRI confirming disc pathology in associated dermatomal / myotomal region **<u>Laminectomy</u>** • Stenotic pattern • Limited levels of function • Deteriorating mobility • Possible bladder / bowel effects • Pain affecting function • MRI evidence of stenotic changes

			HUB ENVIRONMENT WITH MRI ACCESS AND SPACE FOR MDT CLINICS (2 - 3 ROOMS)		**Lamina Flow Theatre and post Anaesthetic facility with X-ray image intensifier required**
Referral reason / Patient presentation	**Primary Care Management**	**Thresholds for Primary Care to initiate a referral**	**Management Pathway for the Integrated MSK Service**	**Thresholds for referral to Hospital / In-patient care**	**Management pathway for Hospital / In-patient care**
Non painful foot drop	**Investigation:** • History • Examination and Assessment • Provisional / working diagnosis(es) **Diagnostics / Imaging:** • **None** **Management (including condition-specific self-care options):** • Explanation of cause	**Refer to Integrated MSK Service (Extended Scope Practitioner / Consultant Physiotherapist)**	**As indicated** **Investigations** • Review MRI scan report • NCS **Management** • Explanation of cause • Surgical appliances re AFO as indicated • Orthopaedic opinion as required		
Referral reason / Patient presentation	**Primary Care Management**	**Thresholds for Primary Care to initiate a referral**	**Management Pathway for the Integrated MSK Service**	**Thresholds for referral to Hospital / In-patient care**	**Management pathway for Hospital / In-patient care**
Spinal pain ***With systemic symptoms (including IVDUs, renal and immuno-compromised patients)***	**Investigation:** • History - unexplained weight loss, severe night pain, fever - History of ca. - Inflammatory markers • Examination and Assessment • Systemic symptoms • Recent foreign travel **Diagnostics:** • Blood screen – full blood screen (CRP, FBC, PSA, myeloma screening, ESR) If ESR > 30 refer	**Use 2WW pathway if suspected condition is covered.** **Refer as emergency to acute hospital if patient is seriously unwell, suspected spinal abscess or discitis** **Refer URGENTLY to Integrated MSK Service (Extended Scope Practitioner / Consultant Physiotherapist) – Appointment within 14 days.**	**1 Patient information** **2 Assessment and examination (Extended Scope Practitioner / Consultant Physiotherapist)** **3 Investigations** • Request urgent MRI **4 Management** • Review MRI scan report **If scan reveals metastatic disease the following management plan should be**	**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** **Offer patient choice of provider for onwards referral to Haematology / General Medicine**	

			followed: - Contact the GP via telephone and present the option for GP to follow up themselves or would like the Integrated service to refer to a spinal orthopaedic surgeon on an urgent basis. If the patient has a recent history of ca. then refer to previous treating team. - Inform the patient depending on outcome of conversation with GP • Patient needs and wants surgery – fitness for surgery, pre-operative assessment, and discharge planning undertaken • Consider referral on to Haematology • Consider referral onto General Medicine - *Pathway note:* *suggest further discussion at the MDT* **5 Outcome tools** • EQ5D • SURE **HUB ENVIRONMENT WITH MRI ACCESS AND SPACE FOR MDT CLINICS (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 Hospital / In-patient care**	**Management pathway for Hospital / In-patient care**
Dorsal / thoracic back pain ***<u>Without</u> systemic***	• History • Examination and Assessment **Investigation:**	**Refer to Integrated MSK Service (General Physiotherapy / Manual Therapy)** if not resolved > 6	**1 Patient information** **2 Assessment and examination (General Physiotherapy /**		**N/A**

symptoms	• **Consider** Blood screen – full blood screen (CRP, FBC, PSA, myeloma screening, ESR) if clinically indicated If ESR > 30 refer **Diagnostics / Imaging:** • If female > 60 years or Male > 70 years, do full blood screen • If significant change in symptoms: • Request plain film x-ray • Request bone density scan if indicated **Management (including condition-specific self-care options):** • First six weeks manage in primary care • Analgesia in line with agreed formularies / guidance • Medical management of osteoporosis	weeks management in Primary Care **Refer to MSK Integrated Service (Extended Scope Practitioner / Consultant Physiotherapist) if** pain is not adequately controlled / resolved **If known myelopathy refer to Orthopaedic Consultant urgently** **If the patient is 'off feet' – refer to A&E**	**Extended Scope Practitioner / Consultant Physiotherapist)** **3 Management:** • Analgesia modification • Consider Nerve blocks / Facet injection • Osteoporosis – consider referral to osteoporosis service(s) / follow osteoporosis pathway • Consider interventional radiology *Pathway note:* *(kyphoplasty) – for discussion at MDT - ? still offering this procedure in the trust, it is on C&H / Mid Susses LPP list* **4 Outcome tools** • EQ5D • SURE **SPOKE ENVIRONMENT AS NO ACCESS TO IMAGING REQUIRED AND ACCESS FOR MDT CLINIC SPACE (2 ROOMS) – INJECTION FACILITITIES REQUIRED**		

Referral reason / Patient presentation	Primary Care Management	Thresholds for Primary Care to initiate a referral	Management Pathway for the Integrated MSK Service	Thresholds for referral to Hospital / In-patient care	Management pathway for Hospital / In-patient care
Myelopathy **(cord compression)** ***i.e.*** • ***Arm pain, numbness and weakness*** • ***Spasticity of legs*** • ***Sensory changes in legs***	**Investigation:** - History - Examination and Assessment - Provisional diagnosis **Diagnostics:** • **<u>None</u>** **Management (including**	**Refer all unless known diagnosis and stable symptoms. Progression of symptoms is key to the urgency of the referral.** **Refer to MSK Integrated Service (Extended Scope Practitioner / Consultant Physiotherapist)**	**1 Patient information** **2 Assessment and examination (Extended Scope Practitioner / Consultant Physiotherapist)** • If myotomal weakness - request urgent MRI scan – more important clinical signs are; Change in balance /	**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** *Pathway note:* *This pathway requires further*	

• ***Sphincter involvement*** • ***Sensory ataxia***	**condition-specific self-care options):** • Explanation of cause • **Stable spondylic cervical myelopathy can be managed with analgesia and collars** **Pathway note: MDT to advise on how to access collars, how long to use etc**	**<u>Exclusions:</u>** ○ Rheumatoid Arthritis with neck pain ○ Additional neuro signs – e.g. cranial nerves, impairment of consciousness ○ Down's Syndrome *The above exclusions list require emergency referral to orthopaedics via A&E*	proprioception +/- brisk reflexes +/- clonus +/- up going plantar(s) Multisegmental weakness **3 Investigations** • Review MRI scan report **4 Management** • Patient needs and wants surgery – fitness for surgery, pre-operative assessment, and discharge planning undertaken • Consider follow up appointment for further review **5 Outcome tools** • EQ5D • SURE **HUB ENVIRONMENT WITH MRI ACCESS AND SPACE FOR MDT CLINICS (2 - 3 ROOMS)**	*MDT revisions.* • *Clarity on primary care management* • *Thresholds for surgical intervention* • *Types of surgical intervention*	

Referral reason / Patient presentation	Primary Care Management	Thresholds for Primary Care to initiate a referral	Management Pathway for the Integrated MSK Service	Thresholds for referral to Hospital / In-patient care	Management pathway for Hospital / In-patient care
NERVE ROOT PAIN (RADICULOPATHY)					
Sciatica ***Brachialgia*** ***<u>Acute (<6 weeks since onset)</u>*** ***Radicular leg or arm pain*** *Make distinction between nerve and*	**Investigation:** • History • Examination and Assessment: ○ Assess for myotomal weakness, absent reflexes and loss of sensation • Nerve root tension / signs **Diagnostics / Imaging:**	**Refer to Integrated MSK Service (Extended Scope Practitioner / Consultant Physiotherapist) only if:** • decrease 2 level myotomal weakness Pathway note: MDT to provide explanation for what is meant by 2 level myotomal weakness • MRC scale for muscle strength drops to 3 or below	**1 Patient information** **2 Assessment and examination (General Physiotherapy / Extended Scope Practitioner)** **3 Management** • Patient education • Analgesia modification • Consider review by General Physiotherapist	**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**	

somatic referred pain	• **<u>None indicated</u>** **Management (including condition-specific self-care options):** • Reassure patient • Patient information • Advise patient to keep mobile • Pain relief in line with agreed formularies / guidance: ○ Paracetamol may provide pain relief ○ there is no evidence that NSAIDs are more effective in improving radicular symptoms than paracetamol or placebo ○ Tramadol (as likely to be least constipatory opiate) ○ Local Neuropathic Pain Guidelines – consider prescribing neuro modulating medication ○ there may be a significant risk of dependence when some of these medications are used for long periods **DO NOT give codeine** (especially if suspected disc prolapse. Secondary constipation and straining may exacerbate disc herniation)	• Evidence of progressive loss of sensation If significant functional impairment or severe unremitting and uncontrolled pain, consider urgent referral to Integrated MSK Service (General Physiotherapy) or contact MSK service for clinical advice.	• If severe – request MRI scan • Review MRI scan report and consider: ○ Nerve block ○ Epidural • Consider surgery as relevant (i.e. foot drop): ○ Patient needs and wants surgery – fitness for surgery, pre-operative assessment, and discharge planning undertaken **4 Outcome tools** • Startback Tool • Pain Detect • EQ5D • SURE **5 Rehabilitation services provided post-operatively by:** • **General Physiotherapy** **HUB OR SPOKE ENVIRONMENT WITH MRI ACCESS AND SPACE FOR MDT CLINICS (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 Hospital / In-patient care	Management pathway for Hospital / In-patient care
Sciatica Brachialgia ***<u>Chronic (>6 weeks since onset)</u>***	**Investigation:** • History • Examination and Assessment • Nerve root tension / signs • Ability to work / ADLs	**Refer to Integrated MSK Service (General Physiotherapy) in the first instance**	**1 Patient information** **2 Assessment and examination (General Physiotherapy / Extended Scope Practitioner)**	**N/A**	**N/A**

Radicular leg or arm pain	affected? • STarTBack Tool STarT Back **Management (including condition-specific self-care options):** • Reassure patient • Patient information • Advise patient to keep mobile • Pain relief in line with agreed formularies / guidance: ○ Paracetamol may provide pain relief ○ there is no evidence that NSAIDs are more effective in improving radicular symptoms than paracetamol or placebo ○ Tramadol (as likely to be least constipatory opiate) ○ Local Neuropathic Pain Guidelines – see previous ○ there may be a significant risk of dependence when some of these medications are used for long periods **DO NOT give codeine** (especially if suspected disc prolapse. Secondary constipation and straining may exacerbate disc herniation	**Refer to Integrated MSK Service (Extended Scope Practitioner / Consultant Physiotherapist) if:** ○ very severe pain and / or continue to require high levels of analgesics and no improvement with physiotherapy	**3 Management** • Patient education • Analgesia modification • Consider review by General Physiotherapist • If severe – request for MRI scan • Review MRI scan report and consider: ○ Facet joint injection (if compression due to facet cyst?) ○ Epidural ○ Nerve block **4 Outcome tools** • Startback Tool • Pain Detect • EQ5D • SURE **HUB OR SPOKE ENVIRONMENT WITH MRI ACCESS AND SPACE FOR MDT CLINICS (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 Hospital / In-patient care	Management pathway for Hospital / In-patient care
MECHANICAL BACK PAIN					
Mechanical back pain	**Symptoms:** • Flare ups	**Manage in Primary Care**	**N/A**	**N/A**	**N/A**

Acute (<6 weeks)	**Investigation:** • History • Examination and Assessment • If signs start to demonstrate neuropathic pain or nerve root pain – **follow nerve root pain pathway** **Management (including condition-specific self-care options):** • Reassure patient • Patient information • Exercise plan • Self management plan • Consider use patient outcome tool • Pain relief in line with agreed formularies / guidance: ○ Paracetamol is the first-line medication, although there is limited evidence regarding its efficacy: ○ if paracetamol alone does not provide sufficient pain control, offer: ○ NSAIDs and/or: ○ weak opioids ○ consider potential benefits and risks of these medications and patient preference when prescribing medications: ○ if NSAIDs or COX-2 inhibitors are prescribed consider the concomitant use of PPI's in patients with additional risk factors. (See Guidelines for Prescribing PPI's in adults, BSUH, October 2009) ○ consider co-prescribing a laxative with opioids to counteract the	**Contact MSK Service for advice if pain is uncontrolled or there is diagnostic doubt**			

	constipating effects of opioids, as straining to defecate may aggravate back pain ○ aim for the lowest dose required for relief of symptoms ○ when prescribing opioids, short-acting agents given at regular intervals, rather than on a pain-contingent basis is recommended ○ evidence suggests that NSAIDs have some effect for short-term pain relief compared to placebo, but there are no benefits compared to paracetamol, narcotic analgesics or muscle relaxants **Pathway note:** MDT to develop further patient material, and GP training/development material to ensure best practice in management of acute mechanical back pain + could copy in some of the primary care 'persistent' mechanical back pain advice to this section. **Note from Angel Busitill** *specifically I think the it might be helpful for primary care to be supported in looking at the psychological factors that have been shown to be associated with increased risk of patients progressing from acute to chronic* *In self-management I would like to review the suggested materials to ensure there is something GPs could give patients access to which described normal reactions to injury and pain, from a psychological perspective and the emotions and beliefs that can get in the way of recovery. This could be kept very simple but could flag*				

	issues such as mood and cognition (catastrophisation e.g) as well as preferred coping styles such as fear-avoidant and the action prone individual (no pain no gain)				
Referral reason / Patient presentation	**Primary Care Management**	**Thresholds for Primary Care to initiate a referral**	**Management Pathway for the Integrated MSK Service**	**Thresholds for referral to Hospital / In-patient care**	**Management pathway for Hospital / In-patient care**
Mechanical back pain ***Persistent (> 6 weeks to < 12 months since onset)***	**Investigation:** • History • Examination and Assessment • Screen for depression using PHQ2 or similar **Management (including condition-specific self-care options):** • Develop a management plan to aid the patient in understanding what to expect and their role and responsibilities in managing the pain. • Continue to offer reassurance and positive messages that encourage the patient to return to normal activities. • If signs of serious disease are still absent, consider initially offering one of the following: ○ Physical activity and exercise programmes ○ Referral for manual therapy ○ Further drug therapy • Consider a different option from the list above if the response to the first-line therapy is not satisfactory. • Brief educational interventions aimed at reducing sick leave and disability may be useful although NICE do not recommend education as a	**Refer to Integrated MSK Service (General Physiotherapy) in the first instance** **Refer to Integrated MSK Service (Extended Scope Practitioner / Consultant Physiotherapist) if:** ○ Non responsive to manual therapy ○ Inadequate response to analgesia ○ Worsening pain ○ Unable to cope at home / work ○ If diagnosis is uncertain ○ Complex biopsychosocial comorbidities	**1 Patient information** **2 Assessment and examination (General Physiotherapy / Extended Scope Practitioner / Consultant Physiotherapist)** **3 Investigations** Include (if diagnostic uncertainty): ○ Bloods ○ X-ray ○ MRI ○ NCS Pathway note: MDT to review usefulness of NCS in this group ○ CT – where MR contraindicated ○ Bone Scan ○ Look for inflammatory disorders, sacroilitis, spondylolisthesis, TB, other medical presentations **4 Management** Consider review by: ○ General Physiotherapy. Consider re-referral to physiotherapy for different approach with clarification ○ Rheumatology if suspected inflammatory arthropathy ○ Escalation to chronic mechanical back pain pathway if all other interventions have been	**N/A** **If referred to Orthopaedic Surgeon – please see treatment option in chronic patients as below**	**N/A**

	sole intervention. • Clinicians need to be aware of the importance of the patient's employment – options for a 'phased return' should be explored in each case. • Patients dealing with disability and loss of employment should be directed specific areas of support e.g. through an occupational health department and specially trained staff		fully trialled and failed. Consider: ○ Functional Restoration Programme (FRP) ○ Pain Management Programme (PMP) ○ Multi-disciplinary and biopsychosocial groups / functional programmes ○ Flare up Plan **5 Outcome tools** • Startback Tool • EQ5D • SURE **HUB OR SPOKE ENVIRONMENT WITH MRI ACCESS AND SPACE FOR MDT CLINICS (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 Hospital / In-patient care**	**Management pathway for Hospital / In-patient care**
Mechanical back pain ***Acute on chronic (chronic patients with flare up)***	**Investigation:** • History • Examination and Assessment • Screen for depression using PHQ2 or similar **Management (including condition-specific self-care options):** • Patient education • Develop a management plan to aid the patient in understanding what to expect and their role and responsibilities in managing the pain. • Continue to offer reassurance and positive messages that encourage the patient to	**Refer to Integrated MSK Service (General Physiotherapy) in the first instance** **Refer to Integrated MSK Service (Extended Scope Practitioner / Consultant Physiotherapist) if:** ○ Previous poor response to manual therapy ○ If seen previously for Pain Management Programme / Functional Restoration Programme ○ If non responsive to physiotherapy ○ Non-response to analgesia ○ Worsening pain	**1 Patient information** **2 Assessment and examination (General Physiotherapy / Extended Scope Practitioner / Consultant Physiotherapist)** **3 Investigations** Include (if not done before / if diagnostic uncertainty): ○ Bloods ○ X-ray ○ MRI ○ NCS ○ CT ○ Bone Scan ○ Look for inflammatory disorders, sacroilitis, spondylolisthesis, TB, other medical	**N/A**	**N/A**

	return to normal activities. • If signs of serious disease are still absent, consider initially offering one of the following: ○ Physical activity and exercise programmes ○ Referral for manual therapys ○ Further drug therapy • Consider a different option from the list above if the response to the first-line therapy is not satisfactory. • Brief educational interventions aimed at reducing sick leave and disability may be useful although NICE do not recommend education as a sole intervention. • Clinicians need to be aware of the importance of the patient's employment – options for a 'phased return' should be explored in each case. • Patients dealing with disability and loss of employment should be directed specific areas of support e.g. through an occupational health department and specially trained staff. • Explore psychosocial factors	○ Unable to cope at home / work ○ Diagnostic confirmation ○ Complex bio-psychosocial comorbidities	presentations **4 Management** Consider review by: ○ General Physiotherapy ○ Rheumatology if suspected inflammatory arthropathy ○ Escalation to chronic mechanical back pain pathway if all other interventions have been fully trialled and failed. Consider: ○ Functional Recovery Programme (FRP) ○ Pain Management Programme (PMP) ○ Multi-disciplinary and biopsychosocial groups / functional programmes ○ Flare up Plan Consider refresher / top up session(s) for Pain Management Programme (PMP) **5 Outcome tools** • Startback Tool • EQ5D • SURE **HUB ENVIRONMENT WITH MRI ACCESS AND SPACE FOR MDT CLINICS (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 Hospital / In-patient care	Management pathway for Hospital / In-patient care
Mechanical back pain ***Chronic (> 12 months)***	**Investigation:** • History • Examination and Assessment • Startback Tool • Screen for depression using PHQ2 or similar	**Refer to Integrated MSK Service (General Physiotherapy)** **Refer to Integrated MSK Service (see triage options**	**1 Patient information** **2 Assessment and examination (General Physiotherapy / Extended Scope Practitioner / Consultant Physiotherapist / Psychologist / Consultant, pain**	**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**	**Lamina Flow Theatre and post Anaesthetic facility with X-ray image intensifier required**

	Be alert for new symptoms and red flags. **Management (including condition-specific self-care options):** • Patient education • Develop a management plan to aid the patient in understanding what to expect and their role and responsibilities in managing the pain. • Continue to offer reassurance and positive messages that encourage the patient to return to normal activities. • If signs of serious disease are still absent, consider initially offering the following: ○ Physical activity and exercise programmes ○ Further drug therapy • Consider a different option from the list above if the response to the first-line therapy is not satisfactory. • Brief educational interventions aimed at reducing sick leave and disability may be useful although NICE do not recommend education as a sole intervention. • Clinicians need to be aware of the importance of the patient's employment – options for a 'phased return' should be explored in each case. • Patients dealing with disability and loss of employment should be directed specific areas of support e.g. through an occupational health department and specially trained staff.	**below) if:** ○ presentation worsening and unable to manage in primary care ○ For diagnostic confirmation ○ Complex bio-psychosocial comorbidities **<u>Note:</u> Integrated MSK Service Spine MDT Triagers to contact patient and request completion of Startback Tool if not completed by GP:** • Review tool results and identify which member of the MDT is best placed to see the patient (i.e. General Physiotherapist, Extended Scope Practitioner +/- Psychologist, Psychologist, Consultant Physiotherapist, Consultant in pain medicine, GPwSI in pain)	**specialist, GPwSI)** • Explore: ○ Psychosocial factors ○ Patient understanding of psychological interventions **3 Investigations** Include (if not done before / if diagnostic uncertainty): ○ Bloods ○ X-ray ○ MRI ○ NCS ○ CT ○ Bone Scan ○ Look for inflammatory disorders, sacroilitis, spondylolisthesis, TB, other medical presentations **4 Management** Consider review by: ○ General Physiotherapy ○ Rheumatology MDT ○ Orthopaedic Consultant – for spinal fusion ○ Psychologist Consider refresher / top up session(s) for Pain Management Programme (PMP), Functional Restoration Programme (FRP) ○ Flare up Plan Consider Third Sector support / services from Arthritis Care / NRAS / Expert Patient Programme Consider surgical interventions / injections For patients with clinical presentations who correlate with this diagnosis intervention the following should be tried in this order:	**management** **Surgical treatments which may be considered;** • **Fusion** • **How is different to a fusion** • **Disc replacement**	

			- Medication - SIJ Injection - Medial branch block (pain scores should be measured immediately after treatment) - Facet nerve rhizolysis ***Pathway note:*** *For MDT clarification and further agreement* *PMP – ? change position on list to reflect patient now learning to live with pain* For patients with previous history of invasive intervention, treatments could be repeated if benefits realised for 8 months or more. Clinician discretion will be applied to these timeframes. **5 Outcome tools** • Startback Tool • EQ5D • SURE **HUB OR SPOKE ENVIRONMENT WITH MRI ACCESS AND SPACE FOR MDT CLINICS (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 Hospital / In-patient care**	**Management pathway for Hospital / In-patient care**
Neck pain **Acute torticollis**	**Symptoms** • Acute torticollis usually resolves within 24–48 hours • Occasionally symptoms may take up to a week to resolve. Recurrence is common **Investigation** • History • Examination and Assessment	**To be managed in primary care**	**N/A**	**N/A**	**N/A**

	- unable to rotate head **Management (including condition-specific self-care options):** • Analgesia in line with agreed formularies / guidance • Advise gentle exercise within the comfort zone • Intermittent heat or a cold pack to help reduce pain and spasm • Maintain a good posture • <u>Advise against:</u> ○ Routine use of a soft cervical collar. If pain on moving the neck is severe, then wearing a soft collar for a few days may help. It is preferable to keep the neck mobile with gentle exercise				
Neck pain with radiculopathy – see brachialgia pathway					
Referral reason / Patient presentation	**Primary Care Management**	**Thresholds for Primary Care to initiate a referral**	**Management Pathway for the Integrated MSK Service**	**Thresholds for referral to Hospital / In-patient care**	**Management pathway for Hospital / In-patient care**
Neck pain non-specific **Acute phase (first 6 weeks)**	**Investigation:** • History • Examination and Assessment **Management (including condition-specific self-care options):** • Reassure patient that neck pain is a very common problem and that the symptoms are likely to resolve • Encourage the patient to	**To be managed in primary care** **Contact MSK Service for advice if pain is uncontrolled or there is diagnostic doubt**	**N/A**	**N/A**	**N/A**

	remain active • Discourage: ○ wearing a cervical collar ○ prolonged absence from work • Correct poor posture • A firm pillow may provide comfort at night • Analgesia in line with agreed formularies / guidance • Patient information				
Referral reason / Patient presentation	**Primary Care Management**	**Thresholds for Primary Care to initiate a referral**	**Management Pathway for the Integrated MSK Service**	**Thresholds for referral to Hospital / In-patient care**	**Management pathway for Hospital / In-patient care**
Neck pain non-specific **Subacute phase** 6 weeks to 12 weeks (no systemic features) **Pathway note** Is there any need to have this section or should it just refer back to / treat as mechanical low back pain	**Investigation:** • History • Examination and Assessment **Management (including condition-specific self-care options):** • Analgesia in line with agreed formularies / guidance • Patient information • Address any psychosocial factors i.e.: ○ Fear or avoidance beliefs ○ Associated anxiety and depression ○ Medico-legal issues ○ Family dynamics	**Refer to MSK service (physiotherapy) –failed primary care management** **Refer to Integrated MSK Service (Extended Scope Practitioner / Consultant Physiotherapist)** if complex psychosocial comorbidities	*WORKING DRAFT* *Pathway note:* *This pathway needs to go back to the spinal MDT for revision* **1 Patient information** **2 Assessment and examination (Extended Scope Practitioner / / Consultant Physiotherapist)** Explore: • Psychosocial factors • Patient understanding of psychological interventions **3 Investigations** Include (if not done before or if diagnostic uncertainty): • Bloods • X-ray • MRI • Nerve Conduction Study – appropriate for isolated neck pain **4 Management**	**N/A**	**N/A**

			• Further physiotherapy / Functional restoration Programme (FRP) Consider pain management - ? injections could be considered **5 Outcome tools** • Startback Tool • EQ5D • SURE **HUB OR SPOKE ENVIRONMENT WITH DIAGNOSTICS ACCESS AND SPACE FOR MDT CLINICS (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 Hospital / In-patient care**	**Management pathway for Hospital / In-patient care**
Neck pain non-specific **Chronic phase more than 12 weeks**	**Investigation:** • History • Examination and Assessment **Management (including condition-specific self-care options):** • Analgesia in line with agreed formularies / guidance, including trial of a low-dose tricyclic antidepressant • Re-examine psychosocial factors periodically • Consider physiotherapy	**Refer to Integrated MSK Service (Extended Scope Practitioner / Consultant Physiotherapist) if:** • No better with physiotherapy and analgesia • If seen previously in FRP / PMP Refer urgently to **Integrated MSK Service (Extended Scope Practitioner / Consultant Physiotherapist)** if suspecting serious spinal abnormality	**1 Patient information** **2 Assessment and examination (Extended Scope Practitioner / / Consultant Physiotherapist)** Explore: • Psychosocial factors • Patient understanding of psychological interventions **3 Investigations** Include (if not done before or if diagnostic uncertainty): • Bloods • X-ray • MRI • CT • Bone Scan • Consider TB, and other medical presentations **4 Management**	**N/A**	**N/A**

			• Further physiotherapy / Functional Restoration Programme (FRP) Consider pain management - ? injections could be considered **5 Outcome tools** • Startback Tool • EQ5D • SURE **HUB OR SPOKE ENVIRONMENT WITH DIAGNOSTICS ACCESS AND SPACE FOR MDT CLINICS (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 Hospital / In-patient care**	**Management pathway for Hospital / In-patient care**
Neck pain whiplash **Acute**	**Symptoms:** • History of sudden or excessive neck extension, flexion, or rotation. Symptoms may be delayed for hours or days after the injury • The two most common symptoms are: ○ Disabling neck pain, with or without referral to the shoulder or arm ○ Headache • Additional symptoms include: ○ Fatigue ○ Dizziness ○ Paraesthesiae ○ Nausea ○ Jaw pain ○ Posterior cervical sympathetic syndrome, including headaches or facial formication (sensation of ants crawling over the face) **Investigation:**	**Manage in primary care first 6 weeks** **Refer to Integrated MSK Service (General Physiotherapy)** after 6 weeks **Refer to Integrated MSK Service (Extended Scope Practitioner / Consultant Physiotherapist)** if progressive intractable pain **If nerve pain suspected see brachialgia pathway**	**1 Patient information** **2 Assessment and examination (Extended Scope Practitioner / / Consultant Physiotherapist)** Explore: • Psychosocial factors • Counselling **3 Investigations** Include (if not done before or if diagnostic uncertainty): • Bloods • X-ray • MRI • Nerve Conduction Study • CT • Bone Scan • Consider TB, and other medical presentations **4 Management** Further physiotherapy	**N/A**	**N/A**

	• History • Examination and Assessment • Examine for: ○ signs of muscular spasm ○ point tenderness ○ neurological problems in the upper or lower limbs (Note: it is safe to assess for range of neck movements) **Beware if have midline cervical tenderness (as this suggests a fracture or dislocation) or other serious injuries** • Exclude spinal cord compression (myelopathy) - **if suspected refer to A&E** • Assess: ○ presence of associated stress, anxiety, or depression and poor concentration ○ Look for 'yellow flags' that indicate psychosocial barriers to recovery and that suggest that the acute injury could progress to become a chronic problem **Management (including condition-specific self-care options):** • Patient education and information • Provide reassurance that whiplash-associated disorder is usually benign and self-limiting • Encourage early return to usual activities and early mobilisation – explain that usual activities may initially be painful, but this is not harmful or indicative of ongoing damage		**5 Outcome tools** • Startback Tool • EQ5D • SURE **HUB OR SPOKE ENVIRONMENT WITH DIAGNOSTICS ACCESS AND SPACE FOR MDT CLINICS (2 - 3 ROOMS)**		

	• Discourage rest, immobilisation, and the use of soft collars • Analgesia in line with agreed formularies / guidance				
Referral reason / Patient presentation	**Primary Care Management**	**Thresholds for Primary Care to initiate a referral**	**Management Pathway for the Integrated MSK Service**	**Thresholds for referral to Hospital / In-patient care**	**Management pathway for Hospital / In-patient care**
Late whiplash	**Investigation:** • History • Examination and Assessment **Management (including condition-specific self-care options):** • Patient education and information • Encourage and facilitate a return to normal activities • Diagnose and treat anxiety and depression where they coexist • Analgesia in line with agreed formularies / guidance	**Refer to Integrated MSK Service (General Physiotherapy)** **Refer to Integrated MSK Service (Extended Scope Practitioner / Consultant Physiotherapist)** if patient at risk of developing chronicity	**1 Patient information** **2 Assessment and examination (Extended Scope Practitioner / / Consultant Physiotherapist)** Explore: • Psychosocial factors • Patient understanding of psychological therapies **3 Investigations** Include (if not done before or if diagnostic uncertainty): • Bloods • X-ray • MRI • Nerve Conduction Study • CT • Bone Scan • Consider TB, and other medical presentations **4 Management** • Further physiotherapy / Functional (Restoration) Programme (FRP) Pain Management or Pain management Programme (PMP) Pathway note: MDT to discuss role of injection treatment in this group **5 Outcome tools**	**N/A**	**N/A**

			• Startback Tool • EQ5D • SURE **HUB OR SPOKE ENVIRONMENT WITH DIAGNOSTICS ACCESS AND SPACE FOR MDT CLINICS (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 Hospital / In-patient care**	**Management pathway for Hospital / In-patient care**
Spinal pain related to pregnancy	**Management (including condition-specific self-care options):** • Advice • If unable to manage in primary care, refer to **Women's Health Physiotherapy**	• refer to **Women's Health Physiotherapy** and access through Sussex MSK	**N/A**	**N/A**	**N/A**

FOR FURTHER INFORMATION ON EVIDENCE BASED CLINICAL PATHWAYS PLEASE REFER TO MAP OF MEDICINE

Pathway note: MDT to complete a full new section on Suspected spinal stenosios

Spine Pathway group 4th December 2013

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Zoe Hall (Physiotherapist, SCT)
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