Physiotherapy Pathway

SELF-CARE AND SELF-MANAGEMENT

Integrated MSK Service Website: https://sussexmskpartnershipcentral.co.uk/

Referral reason / Patient presentation	Physiotherapy PATHWAY
Referral **1a. Post ICATs AP clinic** **1b. Post ICATs triage** **1c. Standard Referral** **1d. Self-referral**	AP's with knowledge of local service may directly refer to physiotherapy interventions and prioritise for urgency. Triagers may directly refer to physiotherapy and clarify urgency. Primary Care, Secondary care professionals, other health and social care professionals Patients must be able to complete a referral form, on-line or hard copy
2. Clinical Triage & Prioritisation	**Confirm patient meets inclusion criteria** **Identify Patients suitable for virtual clinic** • Re Referrals/Self-referral for the same condition within 6/12 of discharge • Condition less than 6/52 duration • Orthopaedic patients – simple (Ortho clinic Crawley/Horsham) • Independent self-referral with LBP (QVH/Crawley/Horsham) **If senior/specific physiotherapist is necessary this should be identified at triage** **Prioritisation of Referrals** **Urgent Referral Criteria (patient seen within working 5 days)** • Recently signed off work due to the condition • Unable to perform duties as a main carer • Significant reduction of sleep due to the condition • Significant loss of function or unable to cope at home • Patient or condition likely to deteriorate if not seen soon • Time related e.g. protocol driven • Recent surgery or fracture • Job at risk Routine referral criteria (patient seen within four weeks) Problem is musculoskeletal in origin and none of the urgent criteria are present

3. Direct to Intervention	APs can triage clinical urgency APs / Physio triagers must be fully aware of access criteria for groups and presentations that can go direct to 1:1 Patients must have a predefined exercise programme in place to be admitted directly into group. If this is not in place an assessment must take place within the group, or if group structure does not allow this the patient must move to 1:1 assessment before joining the group APs must have discussed the group with the patient. If they are not willing to go direct to group they should be offered a 1:1 assessment (patient choice).
4. Virtual Clinic	**Patients suitable for virtual clinic** • **See 2** **Virtual Clinic Process** - Carry out standard telephone assessment process (see telephone assessment proforma) **Outcomes of telephone assessment:** 1 - Advise patient on appropriate management strategy • Complete appropriate documentation • Send out supporting information, e.g. HEP • Send out condition specific leaflets and direct to online resources (hyperlinks / embedded documents) • DC or advise patient to contact if no improvement 2 – Refer on for 1:1 Assessment (30 minute virtual clinic follow up slot Crawley and Horsham) 3 - DC back to referrer or alternative service/pathway (see section 5) **Virtual clinic exclusions:** • Language barriers, e.g. unable to communicate in English • Severe deafness • Poor cognition • Patient choice
5. DC / transfer to other services or pathways	Referrals that do not meet the pathway criteria can be returned to the referrer or sent to other services / pathway. It may also be appropriate to refer on once the patient has been seen 1:1 or via virtual clinic. Onward referral options may include: • GP • ICATs • Rheumatology • Pain clinic/Pain Management programme • Community Services • Wellbeing services/Time to talk/Right track

6. 1:1 Physiotherapy Assessment	**Appointment times:** **30 minutes for post virtual clinic patients unless stipulated otherwise.** **Also to include:** ✔ Post-surgical patients ✔ Routine referrals from peripheral APs (excluding foot and ankle) for Crawley/Horsham **45 minutes for standard referrals** **60 minutes for complex referrals, e.g. multiple co-morbidities, > 1 problem** **Patient Assessment:** • Subjective • Objective • Hypothetical diagnosis • Management plan / shared decision making • Provision of patient information leaflets, access to videos, specific web sites, apps
7a. 1:1 Management	Management will aim to: • Restore function using combined approaches targeting physical and psychosocial obstacles to recovery. All patients: • Will be included in included in shared decision making around their care • Will receive a copy of their care plan. Education and Advice: • Patients will be provided with relevant information, including risks and benefits of interventions • Provide patients with leaflets and information to access web sites and apps. • All education and advice will be delivered using a motivational interview approach where possible. Physical approaches include: • Manual Therapy • Progressive & graded exercise therapy/proprioception • Electrotherapy • Acupuncture – Where poorly controlled pain prevents improvement acupuncture may be appropriate + or – TENS. The physiotherapist must ensure a pain relief pharmaceutical review has been carried out prior to commencing acupuncture (exclusions apply for LBP and OA) • Hydrotherapy • TENS (only as part of a self-management strategy) • Functional rehab / adaptive equipment • Provision of aids/splints • Oedema management • Scar management Biopsychosocial management: • Restore function using combined approaches targeting physical and psychosocial obstacles to recovery. • Explore potential obstacles and co-morbidities that may make self-managing their condition difficult. • Explore the patient's beliefs and behaviours and work towards making meaningful changes. • Establish value based goals

7b. Physiotherapy classes (Appendix 1)	• Group sessions that provide an opportunity to do regular gym based exercise under supervision. • Patients receive an individualised program which will be monitored and progressed by the physiotherapist over the course of the sessions.
7c. Direct to Gym	Low cost arrangement with local gyms/leisure centres. Access to this will be dependent on local arrangements. e.g. TERMS. Patient's preferred option for ongoing rehabilitation. Therapist provides programme and periodic review Where patients are ready for DC and continued gym use would be beneficial for continuing recovery / management.
7d. Hydrotherapy	Hydrotherapy should be considered if exercise on dry land is difficult or contraindicated e.g. Early orthopaedic rehabilitation where the patient is not FWB. It may be appropriate for patients with high levels of pain but only if the appropriate investigations / pharmaceutical review have been considered. Patients may have the opportunity to attend self-funded Hydrotherapy maintenance groups following discharge. This is available at both PRH and Horsham.
7e. 1:1 Technician Grade 3/4	For patients who are not currently suitable to attend rehab groups or find it difficult to independently exercise but need monitoring/reviewing. Carry out basic manual therapy or electrotherapy treatments. These roles are not available at all sites and individuals would have been through a specific competency programme prior to commencing these roles.
7f. Joint AP review (where available)	These sessions should not be used without initial discussion with a senior physiotherapist. Therapists are encouraged to approach a senior colleague if no hypothetical diagnosis or plan had been determined within the first 2 sessions. Rationale for Joint Sessions: • To assist physiotherapists in making a diagnosis • To assist in establishing an appropriate management programme • To determine need for diagnostics or ICATs referral Medication review can be carried out by independent prescriber if service offers this Imaging / investigations can be ordered from physiotherapy and the patient followed up in clinic
8. Outcomes	Peripheral joints (exc hand and wrist) • PSFS • MSK-HQ Spine • STarT Back Hand and wrist • Boston Questionnaire • Hand and Wrist Evaluation Tool

9a. Pain Management Programme	A group based programme aimed at patients with persistent pain which adversely affects their quality of life and where there is significant impact on physical, psychological and social function. The focus of the programme is to improve quality of life with pain rather than provide a ‘cure’ or pain relief. The PMP team consists of psychologists, physiotherapists and specialist nurses. The programme covers: • Understanding pain • Activity pacing • Graded exercise • Flare up management • Medication review • Mood management • Sleep • Communication • Relationships
9b. Direct to ICATs clinic following:	**Appendix 2**
9c. DC summary plan	✔ Referrer should receive DC letter copied to patient ✔ Patient should receive a copy of their DC letter copied to the referrer ✔ Patients can self-refer back into service within 6 months for same condition (see guidelines)

Appendix 1 check which sites offer which classes and outcome measures

Physiotherapy Classes			
		Availability (BGH share classes with RSCH)	
7b (i)	**Upper limb group** **Shoulder group**	RSCH, Crawley, Horsham	Provides specialised rehabilitation for patients with a range of upper limb pathologies in a hospital or community setting. These classes provide a more conducive environment for rehabilitation for both the patient and clinician and allow patients to return to their optimal level of function/activity.

7b (ii)	**BIC**	HPC, RSCH, Crawley, Horsham	Once a week group sessions aimed at patients with chronic pain where no further medical or therapeutic intervention or investigations are deemed appropriate. It aims to encourage patients to take a more active and positive approach to managing their condition. The aim of the programme is to reduce functional disability, increase confidence in carrying out daily activities despite pain, and improve wellbeing and general health.
			
			The programme will cover:
			• Introduction to the Bio psychosocial model
			• Pain Cycle
			• Pacing
			• Setting value based goals
			• Explain Pain: physiology, acute vs chronic, sensitive nervous system etc.
			• Role of imaging in chronic pain
			• Flare up management
			• Introduction to mindful movement
			• Introduction to relaxation
			• Exercise - baseline setting
			• Exercise – specific goals
			• Exercise – anatomy and physiology
			• Activity management
			  • pacing
			  • graded exposure
			  • prioritising
			Barriers to change – examining thoughts and feelings

7b (iii)	**Back Class**	HPC, RSCH, Crawley, Horsham	• Group session that provides an opportunity to do regular gym based exercise under supervision. • Patients receive an individualised program which will be monitored and progressed by the physiotherapist over the course of the sessions. • Provides advice and information about maintaining a healthy back.
7b (iv)	**Lower limb group**	HPC, RSCH, Crawley, Horsham	Provides specialised rehabilitation for patients with a range of lower limb pathologies in a hospital or community setting. These classes provide a more conducive environment for rehabilitation for both the patient and clinician and allow patients to return to their optimal level of function/activity.

7b (v)	**Escape**	HPC, RSCH, Crawley, Horsham	This class is suitable for patients diagnosed with osteoarthritis of the knee or hip. The group provides education and exercise to decrease pain, improve, function and facilitate self-management.
7b (vi)	**TKR**	Crawley, Horsham	This is a group exercise session available for patients following TKR.
7b (vii)	**Balance and mobility**	Crawley, Horsham	This is a group rehabilitation session for patients who have/are at risk of falls.
7b (viii)	**General rehab**	Crawley, Horsham	This is group session that provides individualised exercise programmes for those unable to attend specific classes. Education is provided regarding pain mechanisms and benefits of exercise.

Appendix 2

9b (i)	**Shoulder/elbow**	**Direct to ICATs clinic following:** Discuss/see with senior B6 or above **(1) (1a Urgent)** Joint session with AP **(2)**	**<u>Immediate post assessment (also see ICATS Shoulder/Elbow Pathway)</u>** • Suspected rotator cuff tear with significant weakness/loss of function **(1)** • Acute capsulitis with uncontrolled pain **(2)** • Post dislocation – urgent referral for suspected RC tears Following treatment • Deteriorating or persisting symptoms **(2)** • Impingement – no response to physiotherapy **(2)** • Ulnar neuropathy – progression of intrusive symptoms, fixed sensory loss, muscle wasting **(2)** • Contracted shoulder not responding to Rx and significantly impacting function/sleep **(1)** • Severe degenerative conditions • Post dislocation – Routine referral for suspected ongoing instability ***X-ray initiated for contracted shoulders & SAP if sent from Physio with this diagnosis prior to clinic appointment***

9b (ii)	**Hand/wrist**	**Direct to ICATs clinic following:**
		
		Discuss/see with senior B6 or above **(1)(1a Urgent)**
		
		Joint session with AP **(2)**
			<u>Immediate post assessment</u>
			
			• Carpal tunnel syndrome. Complete Boston Questionnaire if not already done
			  ○ Mild – CTS class
			  ○ Mod – ICATS/AP on site **(2)**
			  ○ Severe – DW AP for secondary care referral
			
			• Dupuytren's/trigger finger **(1)**
			• Complex case history **(1)**
			• Uncontrolled pain **(2)**
			• Ulna neuropathy **(2)**
			
			<u>Following treatment</u>

			• Deteriorating or persisting symptoms **(2)** • Uncontrolled pain **(2)**
9b (iii)	**Spine**	**Direct to ICATs clinic following:** Discuss/see with senior B6 or above **(1)(1a Urgent)** Joint session with AP **(2)**	**<u>Immediate post assessment (also see ICATS spine pathway)</u>** • Suspicion of underlying sinister pathology **(1)** • Inflammatory /infective features (liaison with GP may be appropriate first for bloods) • Progressively worsening neurological symptoms **(2)**, unless painful foot drop **(1)** **<u>Following treatment</u>** • Deteriorating or persisting symptoms despite conservative Management **(2)** • Radicular leg/arm pain or stenotic signs that have not improved with conservative measures/neuropathic meds **(2)** • Uncontrolled worsening pain **(2)** • Suspicion of underlying sinister pathology **(1)** • Inflammatory /infective features (liaison with GP may be appropriate first for bloods) • Progressively worsening neurological symptoms **(2)**, unless painful foot drop **(1)** **<u>Following treatment</u>** • Deteriorating or persisting symptoms despite conservative Management **(2)** • Radicular leg/arm pain or stenotic signs that have not improved with conservative measures/neuropathic meds **(2)** • Uncontrolled worsening pain **(2)**
9b (iv)	**Hip/knee**	**Direct to ICATs clinic following:** Discuss/see with senior B6 or above **(1)(1a Urgent)** Joint session with AP **(2)**	**<u>Immediate post assessment</u>** • Low Oxford/High New Zealand scores. Significant functional limitation and patient wishes to consider surgery where there is a confirmed diagnosis of OA or high suspicion of OA **(1)** • Acute or frequent locking/giving way / instability interfering with function and clinical findings and history supporting meniscal / ligamentous pathology **(1)** **<u>Following treatment</u>** • Deteriorating or persisting symptoms **(2)** ***Should direct ICATs referral with specific presentation e.g. signs of meniscal locking initiate imaging prior to ICATs FU?***
9b (v)	**Foot/ankle**	**Direct to ICATs clinic following:** Discuss/see with senior B6 or above **(1)(1a Urgent)** Joint session with AP **(2)**	**<u>Immediate post assessment (also see ICATS foot/ankle Pathway)</u>** • Acute or frequent giving way / instability of the ankle interfering with function. Clinical findings and history supporting ligamentous pathology. Do immediately if OCD/TD# suspected. Latently if not responded to conservative RX 4-6/52 **(1)** • Suspicion of Tib Post rupture – unable to PF in WB **(1)** **<u>Following treatment</u>**

			• Patient wishes to consider surgery/injection where there is a confirmed diagnosis of OA or high suspicion of OA and not responded to conservative Mx **(2)** • Deteriorating or persistent foot/ankle pain not responding to physiotherapy. Be aware tib post tendinopathies should have MSK podiatry input early **(2)** ***Should direct ICATs referral with specific presentation e.g. signs of OCD/TD# initiate imaging prior to ICATs FU?***

Appendix 2

Implications of Clinical Effective Commissioning (CEC) on Physiotherapy

The implementation of CEC will have an impact on the physiotherapy services throughout the organisation.

OA Hip/Knee – THR/TKR

Patients need to have undergone conservative management options prior to being considered for invasive intervention except in the presence of bone on bone OA.

All patients are expected to have undergone an appropriate graded exercise and strengthening programme.

Implications:

- Increased demand on physiotherapy NP/FU appointments.
    - Where there is no evidence of previous treatment and OA is suspected on the referral patients will be triaged directly into physiotherapy rather than ICATs.

Risks:

- Increased waiting times
- Increased pressure on gym classes
- Unable to fully meet patient expectations (improved knowledge required around surgical risks/benefits/indications)

Opportunities:

- Clinical development
- Patients seen in right place first time
- Reduced number of ICATs and secondary care appointments
- Potential to convert AP time to physio

Spine

The upcoming CQUIN in respect to patients with spinal pain states that the management of these patients needs to be in line with the NICE guidelines:

Key comments

- All patients should have completed a Startback score prior to commencing treatment.
- Acupuncture should not be used for LBP and LBP and sciatica
- TENs electrotherapy corsets and orthotics should not be used for LBP and LBP and sciatica
- A biopsychosocial program of care should be available to those patients scoring as high risk on STarT Back. E.g. PMP, BIC