Developing an Integrated Back Care Pathway
Niall Craig, Aberdeen
Change in Spinal pathway

- NHS Grampian has completely changed the model of spinal care over the past 4 years
- Demonstrable progress made

Continuous Quality Improvement

- Get the right patient to the right person
- Appropriate personnel employed at each step
- Regular MDT meetings
- Closer working between departments
- Streamlining service to avoid dual referrals and unnecessary appointments before imaging complete
- Use national pathway with local adjustments to speed up patient journey
- Improve patient experience and outcomes

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Where we were:

- Pre 2009 – no or little co-operation
- Orthopaedic Spinal Surgeons – 3
- Neurosurgeons – 4
- Spinal referrals per week
- Orthopaedics 45
- Neurosurgery 25
Spinal Pathway Orthopaedic

- Spinal consultants vetting all referrals
- Triage physiotherapists - 2 then 3
- All working with a consultant
- Back pain surgery common
- Waiting times manageable with targets - waits of up to 26 weeks
Changes 2010-2011

• National drive to roll out Lanarkshire model
• Meetings in Perth Royal Infirmary
• Dearth of spinal surgeons
• Aberdeen - 3 then 2 then 1 at times
• Medinet used – not a good solution
Model Shift

- Closer working with neurosurgery
- Combined spinal pathway
- MSK hubs
- Triage now straddling primary and secondary care
- Grampian pathway introduced
**Joint Neurosurgery and Orthopaedic Pathway for the Management of Patients with Low Back Pain With or Without Sciatica**

**as at Sep 2013**

Patient presents with low back pain, nerve root or mechanical back pain, with or without leg symptoms

**No Red flags/ Serious pathology suspected**

- **General Practice/ Physiotherapy**
  - Provide patient with advice sheet (INSERT LINK TO PRINT OFF)
  - Prescribe appropriate analgesia
  - Encourage mobility and to continue work
  - Advise patient that nerve root pain may take several months to settle.
  - Most back pain settles within 6 weeks

**At 3/52 is it settling?**

- **YES**
  - Continue self-management (LINK to patient leaflet)
  - Should return to normal function within 6-8 weeks - **IF NOT, any red flags?**

  - **NO**
    - See next section

- **NO**
  - Referral/ self-referral to physiotherapy

**Symptoms improved with physiotherapy?**

- **YES**
  - Discharged to continue self-management

- **NO**
  - Review analgesia and coping strategies over further 2-4 weeks

  - **6 week review - pain settling?**

    - **NO**
      - See next section

    - **YES**
      - **Escalate to MSK Hub via Sci-Gateway (LINK to HUB info sheet)**
        - Specialist assessment
        - MRI if indicated (LINK to MRI protocol?)
        - Physiotherapy/ Coping strategies/ Closure
        - Onward referral to 2nd care if indicated AND the patient would consider surgery - to Ortho/Neuro via Spinal Pathway or to Pain service

**Red Flags/ Acute Cauda Equina Syndrome or Discitis/Infection Symptoms?**

**Acute Cauda Equina Syndrome**

- Bowel dysfunction
- Bladder dysfunction
- Sexual dysfunction
- Perineal or saddle area sensory disturbance

**Discitis/Infection Symptoms**

- Sudden onset of acute spinal pain
- No history of trauma
- Generally unwell - fever, tachycardia
- Night pain
- Spinal movements grossly restricted by pain/spasm

**Specific Orthopaedic queries can be directed to**
grampian.gporthoenquiry@nhs.net

**LINK to MSK site on NHS inform?**

**Red Flags**

- First acute onset age <20 or >55
- Non-mechanical pain
- Thoracic pain
- PMH-carcinoma, steroids, HIV
- Unwell, weight loss
- Widespread neurology (multiple dermatomes)
- Structural deformity
- Trauma

- **Urgent referral to Spine-GP referral via SCI pathway**

If PMH of Cancer – consider malignant spinal cord compression and refer as emergency to oncology

Otherwise – refer as emergency to A+E

**If PMH of Cancer – consider malignant spinal cord compression and refer as emergency to oncology**

**LINK to MSK site on NHS inform?**
For Management of continuing Chronic Low Back Pain

For longstanding chronic pain with psychosocial dominance or distress indicating a multi-disciplinary team management approach is required.

Refer to Pain Clinic
Via SCI Gateway & include the following information:
Conservative management tried
Any history of back problems
If patient is diabetic or pregnant

Refer to Spinal Specialist
Use SCI Gateway Spinal mailbox. Include the following information:
Conservative management tried
Any history of back problems
If patient is diabetic or pregnant

Discuss with Spinal Specialist
If holistic pain clinic approach not successful and there is a clear mechanical element to the pain (and patient is psychologically ready for an operation), consideration should be given to a referral to a Spinal Surgeon if patient would consider surgery. Discuss with the Spinal Surgeon prior to referral

For Management of Low Back Pain

Lumbar Spinal Stenosis
- Central Canal Stenosis – Lumbar Laminectomy without Fusion
- Lateral Recess Stenosis – Lateral Recess Decompression
- Foramenal Stenosis or Canal Stenosis in the presence of a degenerative Spondylolisthesis – Decompression without Fusion (unless patient has obviously unstable slip or a slip of greater than 1cm)
  + Spondylolisthesis

Lumbar Disc prolapse with uncomplicated sciatica
- NOT appropriate for patient to be seen by a Spinal specialist before 12 weeks after the onset of pain unless there are other red flag symptoms to be taken into account
- No pain at 8 weeks cancel
- No patient should have surgery before 3 months after the onset of pain unless there are other red flag symptoms to be taken into account
- Patients with chronic symptoms unchanged for 2 years or more should not be considered for surgery

Mechanical Back Pain
- Surgery should not be routinely offered for mechanical back pain
- Spinal Surgeons may offer a surgical service e.g. lumbar spinal fusion, disc replacement, Wallis ligament insertion, where a holistic pain clinic/conservative management approach has not been successful.
Model shift

- Better access to early physiotherapy
- Better communication between community physio and hubs
- Clear escalation pathway to triage service and surgeons
- Weekly MDTs with triage physios
Model Shift

• Complex spine MDT again weekly
• Radiology, pain consultants, Spinal surgeons (neuro and ortho)
• Combined on call rota with ortho and neuro spine currently 1 in 6
• Monthly triage physio MDT meetings with chronic pain specialists
Model shift

- E-Vetting
- MRI prior to appointment
- Normal scans or inappropriate findings – back to referrer with advice
- Poor referral returned asking for more information
Model shift ongoing issues

- Massive numbers of facet injections
- Patchy physio cover in Aberdeenshire
- Referrals in for back pain surgery
Model Shift Ongoing Issues

- Dual referrals or those ignoring the pathway
- Lack of resource for chronic pain
- Neurosurgery issues with e-vetting
Tangible benefits

• Personally – seeing fewer dual referrals
• First year – conversion rate rose from 11% to 37.5%
• Waiting times falling on the whole
## Triage service (ESP Physios) Numbers Jan-Jun 2014

<table>
<thead>
<tr>
<th>Advanced Practice Physiotherapist</th>
<th>Presented at MDT</th>
<th>Spinal surgeon appointment</th>
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<tbody>
<tr>
<td>CJS 104</td>
<td>241 (&lt;15%)</td>
<td>162 (&lt;10%)</td>
</tr>
<tr>
<td>AQ 177</td>
<td>Average 9 per week</td>
<td>Average 6/week</td>
</tr>
<tr>
<td>MN 249</td>
<td></td>
<td></td>
</tr>
<tr>
<td>JB 278</td>
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<tr>
<td>GG 330</td>
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<tr>
<td>NH 400+</td>
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AQ statistics 04/2014-11/2014

<table>
<thead>
<tr>
<th>Number of clinics</th>
<th>43</th>
</tr>
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<tbody>
<tr>
<td>Number of patients</td>
<td>260 (64 reviews)</td>
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<tr>
<td>DNA</td>
<td>17 (7%)</td>
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<tr>
<td>X-rays</td>
<td>62 (24%)</td>
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<tr>
<td>MRI</td>
<td>55 (21%)</td>
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<tr>
<td>Bone scan</td>
<td>0</td>
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# AQ statistics 04/2014-11/2014

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Count</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Bloods</td>
<td>0</td>
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<tr>
<td>Physiotherapy</td>
<td>41</td>
<td>16%</td>
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<tr>
<td>Facet Injections</td>
<td>6</td>
<td>2%</td>
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<tr>
<td>SI Joint Injection</td>
<td>0</td>
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<tr>
<td>Trochanteric bursa injection</td>
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<tr>
<td>Epidural/ NRI</td>
<td>2</td>
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NHS Grampian - caring • listening • improving
## AQ statistics 04/2014-11/2014

<table>
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<tr>
<th>Specialty</th>
<th>Count</th>
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<tbody>
<tr>
<td>Dietician</td>
<td>0</td>
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<tr>
<td>Other specialty</td>
<td>2</td>
</tr>
<tr>
<td>Pain clinic</td>
<td>6</td>
</tr>
<tr>
<td>Surgical waiting list</td>
<td>1 (THR)</td>
</tr>
<tr>
<td>X-ray Meeting</td>
<td>86 (33%) 30 to surgical clinic</td>
</tr>
</tbody>
</table>
Model shift latest

- Recently MATS referral centre using NHS24 at start
- 15 % anticipated to be advised to self refer for physio
- First 30 day reports confirm expected numbers
- Watch this space!
Current Waiting Times

- Clinic 08/01/2015
- 8 new patients
- Average wait to be seen 6 weeks
- Inpatient wait 11 weeks
- First time under 18 weeks since targets introduced
The future

• Aim to take all referrals every 6 (or 8) weeks
• Deal with urgent activity the week on call: cancel elective activity
• Deal with rest over next 7 weeks
• Quick effective service better for patients (PROMS) and satisfaction all!
Thank you
Any Questions?