East Sussex Healthcare
NHS Trust

Eastbourne District General Hospital
Kings Drive
Eastbourne
East Sussex
BN21 2UD

Tel: 0300 131 4500
Website: www.esht.nhs.uk

FOI REF: 24/152

11th July 2024

FREEDOM OF INFORMATION ACT

I am responding to your request for information under the Freedom of Information Act. The answers to your specific questions are as follows:

1. **Guidance on who meets criteria for spinal referral (as opposed to urgent referral)**

   Please see attached - iMSK Clinical Pathways Document.

2. **The Trust's guideline on how soon an 'urgent' referral or scan should be done.**

   2-4 Weeks depending on the modality and number of cancer referrals who take priority.

3. **The exclusion criteria for discharge/outpatient management.**

   There is no set exclusion criteria, discharge / outpatient management would be up to the individual clinician / service managing the patient.

If I can be of any further assistance, please do not hesitate to contact me.

Should you be dissatisfied with the Trust's response to your request, you have the right to request an internal review. Please write to the Freedom of Information Department (esh-tr.foi@nhs.net), quoting the above reference, within 40 working days. The Trust is not obliged to accept an internal review after this date.

Should you still be dissatisfied with your FOI request, you have the right of complaint to the Information Commissioner at the following address:

The Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF

Telephone: 0303 123 1113

Yours sincerely

Freedom of Information Department
esh-tr.foi@nhs.net

Hastings and Rother iMSK - Clinical Pathway
Elective Musculoskeletal – Urgent Conditions and Exclusions

East Sussex Healthcare NHS Trust

Urgent Conditions

- Upper and Lower Limb Severe/deteriorating/progressive neurology (> 3 months) and loss of function – Refer to Advanced Practitioner after completing StarBack Tool
- Severe Pain/ Significant loss of function/suspected osteoporotic fracture (non traumatic) – Refer to Advanced Practitioner
- Neck Pain - Severe Pain/ Post trauma no fracture – Refer to Advanced Practitioner
- Acute/Traumatic cuff tear - No fracture and suspected cuff tear – Refer to Advanced Practitioner
- Joint pain (suspected inflammatory) See Rheumatology pathway
- Traumatic Injuries (if A&E not required) - Avascular necrosis (confirmed by urgent x-ray) /Tendon rupture/avulsion or problems with THR/previous surgery – Refer to Advanced Practitioner
- Significant loss of ADL's and pain relating to: hip/knee, foot and ankle, shoulder, elbow, hand and wrist - May include complex co-morbidities – Refer to Advanced Practitioner

Key and Notes

- Clear – Treat in Primary Care
- Light Green – Refer to Physio via iMSK
- Green – Refer to Advanced Practitioner via iMSK
- Dark Green – Refer to Orthopaedic Consultant via iMSK
- Yellow – Refer to Podiatry via iMSK
- Orange – Refer to Orthotics via iMSK
- Pink – Refer to Rheumatology via iMSK

Please send the iMSK Referral form in via NHS e-Referral Service

We also accept advice and Guidance Request via NHS e-Referral Service

iMSK Urgent and Exclusions Version: 2019 - May

Exclusions

- Suspected cancer 2ww – refer via eRS
- Traumatic fractures (exclude osteoporotic) – Direct to A&E/Fracture Clinic
- Under 16 years old – refer to Children's Physiotherapy or Orthopaedics or Integrated Therapies Service (CITS) for neurodevelopmental Urgent A&E referrals – Direct to A&E
- Patients requiring intermediate care or community based multi-disciplinary input.
- Patients requiring neurological physiotherapy.
- Patients with symptoms/signs of cauda equina syndrome/ metastatic cord compression/spinal infection - bleep the on call Reg regarding A&E admission For further information see Spinal Pathway
- Rheumatology conditions - Refer via eRS directly to Rheumatology Services or treatments commissioned by the NHS England under the heading of Specialist Commissioning for Rheumatology are not included Services for people with autoimmune connective tissue diseases and vasculitis, services for people with inherited disorders of connective tissue, services for people with rare metabolic sclerosing and dysplastic bone diseases, services for people with defined highly specialised services including Ehlers Danlos syndrome.
- Patients with multiple red flags where serious pathology is suspected (combinations of Immunosuppressed (other than steroids), Hx of serious pathology, Fever, Unexplained weight loss (> 10% body weight in last 3-6/ 12), Severe, unremitting night pain, Gait disturbance, hx of systemic illness – Refer to 2ww if clinically indicated
- Pregnancy related pelvic/hip pain – Refer via email to Women's Health Physiotherapy
- Charcot arthropathy suspected, x-ray and refer urgently to Diabetic Foot
- Undiagnosed suspected spinal infection – Refer to A&E

Hastings and Rother iMSK - Clinical Pathway
Elective Musculoskeletal Conditions – Spine

East Sussex Healthcare NHS Trust

Radicular Pain (Upper or Lower Limb)

First 6 weeks of pain:
Caution
- Red Flags

Diagnostics before referral:
- None indicated

Clinical Tests:
- Myotomal, Dermatomal, reflexes and basic vascular test

Management
- Advice activity modification and exercise (www.arthritisresearchuk.org)
- Analgesic ladder (including neuropathic pain medication) (NICE)

After 6 weeks:
- mild/settling

Management
- Routine referral to Physiotherapy

After 6 weeks:
- No response to physiotherapy
- Complex (diagnosis uncertain/comorbidities)

Management
- Routine referral to Advanced Practitioner

After 6 weeks:
- Severe/deteriorating/progressive neurology (> 3 months)
- Loss of function

Management
- Urgent referral to Advanced Practitioner after completing the startback tool

Caution

see exclusions page:

- Past medical history of Cancer
- CES: Bowel/bladder/sexual dysfunction/ saddle anaesthesia
- Fever, night sweats, Unexplained weight loss (> 10% body weight in last 3-6/12)
- Atypical Thoracic pain
- Progressive neurological deficit/gait disturbance/ acute motor deficit/foot drop
- Severe, unremitting night pain

Mechanical Back Pain (Lumbar and Thoracic)

First 6 weeks of pain:
Caution
- Red Flags

Diagnostics before referral:
- None indicated

Clinical Tests:
- Myotomal, Dermatomal, reflexes and basic vascular test

Management
- Advice activity modification and exercise (www.arthritisresearchuk.org)
- Analgesic ladder (NICE)

After 6 weeks:

Management
- Routine referral to Physiotherapy

If:
- no response to Physiotherapy

Management
- Routine referral to Advanced Practitioner

If:
- Severe Pain/ Significant loss of function/ suspected osteoporotic fracture (non traumatic)
- Undiagnosed suspected spinal infection

Management
- Urgent referral to Advanced Practitioner

Neck Pain (including whiplash)

First 6 weeks of pain:
Caution
- Trauma

Diagnostics before referral:
- None indicated

Clinical Tests:
- Myotomal, Dermatomal, reflexes and basic vascular test

Management
- Advice activity modification and exercise (www.arthritisresearchuk.org)
- Analgesic ladder (NICE)

After 6 weeks:

Management
- Routine referral to Physiotherapy including risk Stratification\startback outcome tool

If:
- Deteriorating
- No response to Physiotherapy
- Complex (diagnosis uncertain/comorbidities)

Management
- Routine referral to Advanced Practitioner

If:
- Severe Pain/ Post trauma no fracture

Management
- Urgent referral to Advanced Practitioner

Hastings and Rother iMSK - Clinical Pathway
Elective Musculoskeletal Conditions – Shoulder

NHS East Sussex Healthcare NHS Trust

Acute/Traumatic cuff tear

Diagnostics before referral:
- If significant injury x-ray (to exclude bony injury/fracture)

Management:
- Analgesic ladder (NICE)

If:
- No fracture and suspected cuff tear

Management
- Urgent referral to Advanced Practitioner

Frozen Shoulder

Diagnostics before referral:
- X-ray (A-P, axial)

Management:
- Advice activity modification and exercise (www.arthritisresearchuk.org)
- Analgesic ladder (NICE)
- Injection (if available in practice)

If:
- Mild/Moderate Symptoms

Management
- Routine referral to Physiotherapy

If:
- No response to Physiotherapy
- Severe Symptoms
- Complex (diagnosis uncertain/ comorbidities)
- Injection (if not available in practice)
- Review for possible surgical management/distension

Management
- Routine referral to Advanced Practitioner

OA Shoulder

Diagnostics before referral:
- X-ray (A-P, axial)

Management:
- Advice activity modification and exercise (www.arthritisresearchuk.org)
- Analgesic ladder (NICE)

If:
- Early Osteoarthritis

Management
- Routine referral to Physiotherapy

If:
- No response to Physiotherapy
- Complex (diagnosis uncertain/ comorbidities)
- Review for possible surgical management

Management
- Routine referral to Advanced Practitioner

If:
- Severe, ongoing symptoms to review for possible surgical management

Management
- Routine referral to Orthopaedics Consultant

Instability

Diagnostics before referral:
- X-ray (A-P, axial) to exclude bony injury/fracture if significant trauma

Management:
- Advice activity modification and exercise (www.arthritisresearchuk.org)
- Analgesic ladder (NICE)
- Injections are not advised (NICE)

If:
- Recurrent instability and no history of trauma

Management
- Routine referral to Physiotherapy

If:
- No response to Physiotherapy
- Complex (diagnosis uncertain/ comorbidities)
- Recurrent post-trauma instability to review for possible surgical management

Management
- Routine referral to Advanced Practitioner

AC Joint or Sub-acromial Pain
(Degenerative cuff tears, Bursitis, Tendinopathy, Calcific tendinopathy)

First 6 weeks:

Diagnostics before referral:
- None

Management:
- Advice activity modification and exercise (www.arthritisresearchuk.org)
- Analgesic ladder (NICE)
- Injection (if available in practice)

After 6 weeks:

Management
- Routine referral to Physiotherapy

If:
- No response to physiotherapy
- Complex (diagnosis uncertain/ comorbidities)
- Injection (if not available in practice)

Management
- Routine referral to Advanced Practitioner

Hastings and Rother iMSK - Clinical Pathway
Elective Musculoskeletal Conditions – Elbow

East Sussex Healthcare NHS Trust

Tennis/Golfer's Elbow

First 6 weeks of pain:
Diagnostics before Referral:
- None

Management
- Advice activity modification and exercise (www.arthritisresearchuk.org)
- Analgesic ladder (NICE)
- Injections if severe (if available in practice)
- Tennis elbow brace
- If Symptoms severe Routine referral to Physiotherapy

After 6 weeks:
Management
- Routine Referral to Physiotherapy

If:
- no response to Physiotherapy

Diagnostics before Referral:
- Injection(if not available in practice)

Management
- Routine referral to Advanced Practitioner

If:
- Persistent severe symptoms

Management
- Routine referral to Orthopaedic Consultant to review for possible surgical management

Olecranon Bursitis

Diagnostics before Referral:
- Check for signs of infection

Management
- Antibiotics/rest if infection present

If:
- painful/not resolving
- diagnosis unclear

Management
- Routine referral to Orthopaedics Consultant for review for confirmation of diagnosis and possible surgical management

Ulnar Neuropathy

Diagnostics before Referral:
- None

Management
- Advice re avoidance of aggravation (leaning on elbow, prolonged elbow flexion)
- Advice re splinting/wraps to avoid elbow flexion at night

If:
- Diagnosis unclear

Management
- Routine referral to Advanced Practitioner

If:
- Severe, ongoing symptoms

Management
- Routine referral to Orthopaedics Consultant for review for possible surgical management

Suspected Osteoarthritis

Diagnostics
- None

Management
- Advice activity modification and exercise (www.arthritisresearchuk.org)
- Lifestyle changes
- Splints

If:
- Mild/moderate symptoms

Management
- Routine referral to Physiotherapy

If:
- Moderate/Severe symptoms

Management
- Routine referral to Advanced Practitioner for diagnosis/ investigation

Synovitis

- Follow Rheumatology Pathway

Hastings and Rother iMSK - Clinical Pathway
Elective Musculoskeletal Conditions – Hand and Wrist

NHS East Sussex Healthcare NHS Trust

Trigger Finger

Diagnostics before Referral:
- None

Management
- Up to 2 injections (if available in practice)

If:
- Injection not available in practice
- Unresponsive to injections

Management
- Routine referral to Advanced Practitioner

If:
- Fixed flexion contracture
- Symptoms persistent after 2 injections
- significant functional impairment

Management
- Routine referral to Orthopaedic Consultant

Ganglia

Diagnostics before Referral:
- None

Management
- Advice regarding nature of condition (www.nhs.uk/conditions/ganglion)

If:
- Pain
- Loss of Function/increasing size
- Suspicious

Management
- Routine referral to Advance Practitioner

Osteoarthritis (Wrist or hand)

Diagnostics before Referral:
- None

Management
- Advice regarding management
- Give splints
- Analgesic ladder (NICE)
- Injection (if available in practice)

If:
- Splinting required
- Hand exercises required

Management
- Routine referral to Physiotherapy

If:
- no response to Physiotherapy
- Complex (diagnosis uncertain/ comorbidities)
- Injection (if not available in practice)
- Conservative management has been exhausted to review for possible surgical management

Management
- Routine referral to Advanced Practitioner

Carpal Tunnel Syndrome

If mild/moderate symptoms:

Diagnostics before Referral:
- None
- Do not do Nerve Conductive Study

Management
- Give Splint for night symptoms up to 12 weeks
- Injection (if available in practice)

If:
- Complex (diagnosis uncertain/ comorbidities)
- Injection (if not available in practice)
- Conservative management has been exhausted to review for possible surgical management

Management
- Routine referral to Advanced Practitioner

If:
- Severe nerve compression
- Permanent sensory loss
- Thenar wasting

Management
- Urgent referral to Orthopaedic Consultant

DE Quervains

Diagnostics before Referral:
- None

Management
- Advice activity modification and exercise (www.arthritisresearchuk.org)
- Analgesic ladder (NICE)
- Injection (if available in practice)

If:
- Specialist Splinting required
- Hand exercises required

Management
- Routine referral to Physiotherapy

If:
- Complex (diagnosis uncertain/ comorbidities)
- Injection (if not available in practice)
- Conservative management has been exhausted to review for possible surgical management

Management
- Routine referral to Advanced Practitioner

Dupuytren's

If:
- Deformity affecting function with >30 degrees fixed flexion at MCP or any deformity of PIP
- Limitation to hand function

Management
- Routine referral to Orthopaedics Consultant

Wrist Synovitis

Follow Rheumatology Pathway

Hastings and Rother iMSK - Clinical Pathway
Elective Musculoskeletal Conditions - Hip

East Sussex Healthcare NHS Trust

Traumatic Injuries (if A&E not required)

Considerations
- Avascular necrosis/Tendon rupture/ avulsion or problems with THR/previous surgery

Diagnostics before Referral:
- Urgent x-ray

Management
- Urgent referral to Orthopaedics Consultant

Anterior Hip Pain (Non-arthritic pain)

Considerations
- Greater Trochanteric hip pain (can consider injection)
- Groin pain
- Adductor pain
- Muscle sprains
- Lateral hip clicking
- Hip impingement

Diagnostics before Referral:
- None

Management
- Routine referral to MSK Physiotherapy

If:
- No response to Physiotherapy
- Complex/diagnosis uncertain
- Deteriorating

Diagnostics before Referral:
- None

Management
- Routine referral to Advance Practitioner

Osteoarthritis (know or suspected)/ Post Surgical History/Congenital Problems (Non Traumatic)

Considerations
- History of childhood hip disease
- Previous/worsening hip dysplasia

Diagnostics before Referral:
- x-ray

If:
- Mild/moderate osteoarthritis

Management
- Advice activity modification and exercise (www.arthritisresearchuk.org)
- Analgesics Ladder
- Weight Management
- Complete KOOS/HOOS outcome measure

If:
- Mild/moderate Osteoarthritis and not responding to Primary Care Management

Management
- Routine referral to Physiotherapy

If:
- No response to Physiotherapy
- Complex/diagnosis uncertain
- Deteriorating

Management
- Routine referral to Advanced Practitioner

If:
- Severe Osteoarthritis
- Significant loss of function
- Childhood hip disease

Management
- Routine referral to Orthopaedics Consultant

Hastings and Rother iMSK - Clinical Pathway
Elective Musculoskeletal Conditions – Knee

East Sussex Healthcare NHS Trust

Knee Pain Under 40

First 6 weeks of pain:
Diagnostics before Referral:
- None

Management
- Advice activity modification and exercise (www.arthritisresearchuk.org)
- Analgesic ladder (NICE)

After 6 weeks of pain:
Considerations
- Patellofemoral/anterior knee pain, clicking knee joint
- Tendinopathies- knee
- Simple soft tissue strains/ ligament sprains
- Suspected simple bursal pathologies- knee

If:
- No response to analgesic ladder
- no true locking/giving way/not meeting surgical criteria

Management
- Routine referral to Physiotherapy

If
- Conservative management has been exhausted

Management
- Routine referral to Advanced Practitioner for additional diagnostics

If
- Recent traumatic haemarthrosis
- Conservative measures have been exhausted
- Evidence of true locking and giving way (not due to pain)

Management
- Routine referral to Orthopaedic Consultant

Osteoarthritis (know or suspected) Over 40

First 6 weeks of pain:
Diagnostics before Referral:
- X-ray (including weight bearing – AP, lat and Sky views)

Management
- Advice activity modification and exercise (www.arthritisresearchuk.org)
- Analgesic ladder (NICE)

After 6 weeks of pain and:
- Mild abnormal x-ray
- adverse to surgical intervention no true locking/ giving way

Management
- Routine referral to Physiotherapy

If
- Mild/Moderate abnormal x-ray and ADL severely affected/Conservative management has been exhausted

Management
- Routine referral to Advanced Practitioner

If
- Severe abnormal x-ray/evidence of true locking not responding to conservative management to review for possible surgical management

Management
- Routine referral to Orthopaedic Consultant

Other Knee Conditions

- Bakers Cyst's
- Calcifications
- Tendinopathy
- Adult with previous diagnosis of Osgood Schlatter
- Muscle Strain

Management
- Analgesic ladder (NICE)

After 6 weeks and:
- Previous diagnosis of Osgood Schlatter
- Muscle Strain
- Tendinopathy

Management
- Routine referral to Physiotherapy

Suspected Inflammatory Arthritis

Follow Rheumatology Pathway

Hastings and Rother iMSK - Clinical Pathway
Elective Musculoskeletal Conditions – Foot and Ankle Page 1

East Sussex Healthcare NHS Trust

Plantar heel pain

First 6 weeks of symptoms:
Diagnostics before Referral:
- None

Management
- Education (www.heelfixkit.com)
- Education re natural history, self-management for 6-9 months
- Footwear – avoiding totally flat or high shoes
- Calf muscle exercises/stretches
- Analgesic ladder (NICE)
- Activity modification/pacing
- Injections are not advised (NICE)

If:
- Symptoms more than 6 weeks

Management
- Routine referral to Podiatry

If:
- No response to podiatry
- Bilateral presentation +/- other joint Sx
- No response to podiatry
- Complex (diagnosis uncertain/comorbidities)

Management
- Routine referral to Advanced Practitioner

Notes

Standard Examination points for first 6 weeks of symptoms
- nerve root pain
- inflammatory disease
- Fracture
- joint pathology
- peripheral neuropathy
- plantar skin pathology (refer directly to Podiatry)
- Absence of neuro or vascular symptoms
- For pathology specific tests see pathway

Tendinopathy

First 6 weeks of symptoms:
Investigation:
Examination/Hx
- Pain, swelling
- Too many toes sign (PTTD)
- Tip toe test (PTTD)
- Examine for clunking, suluxing tendon (Peroneal)
- Muscle power testing (note: Peroneal tendon may be felt to sublux)
- Nodular tendon (Achilles)
- Thompson's triad test (Achilles)

Diagnostics before Referral:
- none

Management
- As per Metatarsalgia
- If suspected full rupture of tendon refer to A&E)

If:
- Symptoms more that 6 weeks
- If source of symptoms likely to be foot posture related

Management
- Routine referral to Podiatry

If:
- Symptoms more than 6 weeks
- In source of symptoms likely to be mechanical overloading
- No response to podiatry
- Complex (diagnosis uncertain/comorbidities)

Management
- Routine referral to Physiotherapy

If:
- Severe, ongoing symptoms to review for possible surgical management

Management
- Routine referral to Orthopaedics Consultant

Metatarsalgia

First 6 weeks of symptoms
Diagnostics before Referral:
- X-ray (if ?fracture/joint pathology)
- Blood test (if ?RA/sero-ve/gout)

Management
- Education footwear – avoid flat, high or tight shoes. Try supportive/cushioning footwear (trainers)
- Over the counter orthotics with met dome
- Protect, optimal loading, ice, compress, elevate (POLICE)
- Avoid heat, alcohol, running, massage (HARM)
- Analgesic ladder (NICE)
- Activity modification/pacing

If:
- Symptoms more than 6 weeks

Management
- Routine referral to Podiatry

If:
- No response to podiatry
- Increasing difficulty with ADLs
- No response to podiatry
- Complex (diagnosis uncertain/comorbidities)

Management
- Routine referral to Advanced Practitioner

If:
- Severe, ongoing symptoms to review for possible surgical management

Management
- Routine referral to Orthopaedics Consultant

Hastings and Rother iMSK - Clinical Pathway
Elective Musculoskeletal Conditions – Foot and Ankle Page 2

East Sussex Healthcare NHS Trust

Ankle Sprain

Investigation:
Examination/Hx
- Balance/single leg stand
- Ottawa ankle rules (acute)

Diagnostics before Referral:
- X-ray (lateral and AP foot)

Management
- Education
- Protect, optimal loading, ice, compress, elevate (POLICE)
- Avoid heat, alcohol, running, massage (HARM)
- Advise rest and activity modification e.g. sports
- Over the counter ankle support and Footwear advice
- Early treatment at A&E if suspected fracture

If
- Not improving after 6 weeks
- Severely affecting ADL
- Suspicion of tendon/ligament injury

Management
- Routine referral to physiotherapy

If
- Not improving after 6 weeks
- Severely affecting ADL
- Results of diagnostics indicates specialist assessment
- Suspicion of tendon/ligament rupture
- No response to physiotherapy
- Complex (diagnosis uncertain/comorbidities)

Management
- Routine referral to Advanced Practitioner

If:
- Severe, ongoing symptoms to review for possible surgical management

Management
- Routine referral to Orthopaedics Consultant

Midfoot pain

First 6 weeks of symptoms:
Investigation:
Examination/Hx
- Exclude neuroarthropathy (Charcot's) if peripheral neuropathy with normal blood flow. Warmth, redness, swelling

Diagnostics before Referral:
- X-ray (if bony/joint pathology suspected)

Management
- Protect, Optimal loading, ice, compress, elevate (POICE)
- Avoid heat, alcohol, running, massage (HARM)
- Analgesic ladder (NICE)
- Activity modification/pacing
- Footwear changes - lacing

If
- Symptoms more than 6 weeks
- Tendon pathology suspected

Management
- Routine referral to Podiatry

If
- Symptoms more than 6 weeks
- Joint pathology suspected
- No response to podiatry
- Complex (diagnosis uncertain/comorbidities)

Management
- Routine referral to Advanced Practitioner

If:
- Severe, ongoing symptoms to review for possible surgical management

Management
- Routine referral to Orthopaedics Consultant

Limb Length difference

Investigation:
Examination/Hx
- Bone surgery
- hip dysplasia
- total hip replacement

Diagnostics before Referral:
- None

Management
- Over the counter heel raise if <1cm for short side

If
- LLD suspected <2cm

Management
- Routine referral to Podiatry

If
- LLD suspected >2cm

Management
- Routine referral to Orthotics

If
- LLD confirmed of >1cm and failure to manage with conservative treatment
- Significant decrease in ADL function

Management
- Routine referral to Advanced Practitioner