

**South Worcestershire  
Integrated Clinical Assessment &  
Treatment Service (ICATS)  
Orthopaedic Practitioners Guidelines**

**ICATS**  
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## 1 ROLE OF SERVICE.

The ICATS provides orthopaedic assessment by experienced and specially trained physiotherapists and podiatrists who are working with an extended scope of practice. These clinicians are referred to as Orthopaedic Practitioners. The referring GP provides medical support and takes back any non-orthopaedic elements of the patient's care. The ICATS is provided by the PCT to streamline the referral and management of patients referred to secondary care.

- ICATS provides an electronic triage service
- Electronic triage of ICATS referral forms to be undertaken by Extended Scope Physiotherapists
- ICATS encompasses all specialities involved in musculoskeletal & chronic pain management
- Patients will be directed to a variety of treatment services based in existing premises across South Worcestershire

## 2 AIMS OF THE SERVICE.

- To assess, advise and manage patients who have musculoskeletal/orthopaedic problems with their spine or extremities ***particularly where conservative care through physiotherapy, podiatry, osteopathy or chiropractic has failed***
- To arrange, where necessary, relevant investigations e.g. MRI, X-ray, bloods and nerve conduction studies
- To identify patients who are appropriate for surgical intervention and make onwards referral
- To identify or exclude serious pathology
- To identify patients who require assessment by other services e.g. Pain Clinic, Neurology, Orthopaedics, Rheumatology, Physiotherapy, Orthotics, Podiatry, Occupational Therapy and arrange for patients to be referred appropriately
- To work closely with Orthopaedic Consultants, in the relevant sub-specialities to ensure effective care for patients
- To assess patients with chronic musculoskeletal pain

## 3. PHYSIOTHERAPY AND ORTHOPAEDIC PRACTITIONER SERVICE DIFFERENCES

- ICATS manages patients with complex musculoskeletal/orthopaedic conditions who are not improving with normal conservative care including physiotherapy
- Patients with either complex spinal problems, or those presenting with significant neurological problems are suitable for ICATS management.
- Unless a clear indication for either pre-surgical assessment or further investigations are required, patients should ideally have trialled physiotherapy or podiatry as appropriate in the first instance before consideration of referral to ICATS.
- With reference to all acute low back pain and sciatic problems, physiotherapy should be trialled for approximately 6-8 weeks before referral to ICATS.

- Please see attached flow chart at the end of this document for specific clinical detail of referral pathway and conditions

#### **4. REFERRAL PATHWAY.**

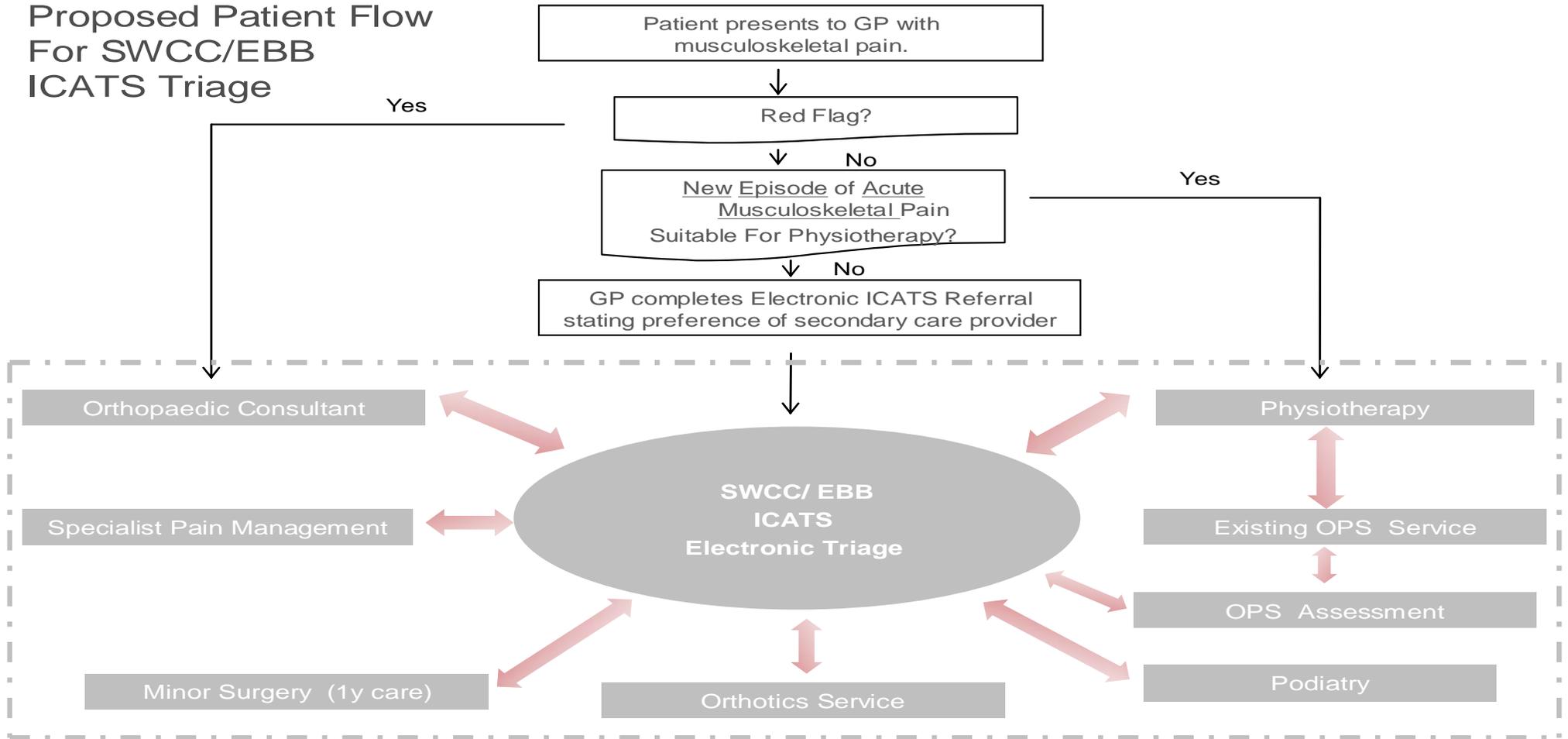
Patients will be referred by GPs electronically to a dedicated e-mail address on a standard proforma to then be triaged by an Orthopaedic Practitioner.

- Mechanisms to allow physiotherapists and podiatrists to refer into ICATS will be developed.
- See Chart 1 overleaf for detail of patient flow through ICATS,

#### **5. INAPPROPRIATE REFERRALS**

Where an electronic referral does not match with the referral criteria, or have sufficient clinical detail, the referrer will be notified via the electronic proforma explaining the reasons for it not being accepted by the service.

# Proposed Patient Flow For SWCC/EBB ICATS Triage



ICATS NOT just a triage service. ICATS encompasses all specialities involved in musculoskeletal & chronic pain management  
 Electronic triage of ICATS referral forms to be undertaken by Extended Scope Physiotherapists.  
 Patients will be directed to a variety of treatment services based in existing premises across South Worcestershire

## **6. CONDITIONS COVERED BY THE ORTHOPAEDIC PRACTITIONER SERVICE**

Please see clinical flow charts at end of document for care pathways (pages 9-15).

### **6 CLINIC ORGANISATION**

- Clinic locations are shown below.
- The ICATS will be supported by administration and clerical staff at each of the locations.
- All patients will receive a comprehensive assessment and a management plan will be developed, in consultation with the patient.
- If the Orthopaedic Practitioner considers it necessary, the duration of an appointment may be altered, at the clinician's discretion.
- All appointment letters will clearly state that the patient will be seen by an Orthopaedic Practitioner, who will be a Physiotherapist Specialist.

### **DIRECTORY OF CLINIC LOCATIONS**

#### **Malvern Community Hospital**

Malvern Community Hospital, Malvern  
WR14 2AW

#### **Prospect View Malvern**

Prospect View, 300 Pickersleigh Rd, Malvern, WR14 2GP

#### **Evesham Community Hospital**

Outpatients Department, The Richards Suite, Evesham Community Hospital  
WR11 4JH

#### **Corbett Medical Centre, Droitwich**

Physiotherapy Department, Corbett Medical Centre, Droitwich WR9 7BE

#### **Droitwich Medical Centre, Droitwich**

Droitwich Medical Centre Ombersley Street Droitwich Spa WR9 8RD

#### **Turnpike House Medical Centre Worcester**

37 Newtown Road Worcester WR5 1EE

## **7 INVESTIGATIONS.**

### **X-RAYS.**

These will be requested when appropriate, by the Orthopaedic Practitioner; all clinicians working in ICATS who request X-rays will have completed an appropriate course in radiation protection for clinicians requesting radiological investigations.

A list of Orthopaedic Practitioners able to request X-rays is held by the X-Ray Department at Worcester Royal Hospital.

All x-rays will be ordered in accordance with the Royal College of Radiologists Guidelines and in accordance with Worcestershire PCT's and Worcestershire Acute Trust's protocol for Orthopaedic Practitioners requesting X-rays.

### **MRI SCANS**

MRI scans will be requested when appropriate by the Orthopaedic Practitioner. All clinicians working in ICATS who order MRI scans will have completed an appropriate course, in accordance with local agreement. This is indicated in Worcestershire PCT's and Worcestershire Acute Trust's protocol for Orthopaedic Practitioners requesting MRI scans.

A list of Orthopaedic Practitioners able to request MRI scans is held by the administration department at Worcester Imaging Centre.

### **BLOOD TESTS**

Where appropriate the Orthopaedic Practitioner will request blood tests for patients, all Orthopaedic Practitioners will have completed appropriate training.

### **NERVE CONDUCTION STUDIES**

Where appropriate the Orthopaedic Practitioner will request nerve conduction studies by directing patients to the neurophysiology department, in line with the agreed protocol.

## **8 REFERRALS TO OTHER SPECIALITIES**

Following assessment in the clinic the Orthopaedic Practitioner may need to refer the patient on to another clinical service, or speciality. This will include Physiotherapy, Podiatry, Orthotics, Pain Clinic, Consultant specialities.

## **9 ADMINISTRATIVE SUPPORT**

For every patient seen in the ICATS, a dictated summary of the assessment findings and management will be sent to the referring clinician.

## **10 CLINICAL GOVERNANCE**

Physiotherapists are autonomous practitioners and have their own Professional Liability Insurance, where their role has been extended, with the agreement of their employer, the employing Trust stands vicariously liable.

It is the responsibility of each Orthopaedic Practitioner to hold clinical responsibility for all situations where they are competent to do so and must not engage in activities beyond their own scope of competence.

All Orthopaedic Practitioners have a responsibility to maintain their Continuing Professional Development; the employing Trust will assist clinicians in this by providing support and help with training.

In addition the Trust will arrange opportunities for peer supervision and will maintain the consultant shadowing programme to allow the Orthopaedic Practitioners to maintain close links with the consultants in secondary care centres.

# ICATS Clinical Spinal Pathway

Acute spinal pain or acute on chronic

Chronic spinal (+/- limb pain where back/neck pain is the predominant symptom)

Radicular pain >6/52

RED FLAGS / SERIOUS PATHOLOGY

**Physiotherapy**  
Acute Spinal    Acute on Chronic  
 NSAIDs            Reactivation exercise  
 Analgesia        Pain management  
 Advice  
 Reassurance  
 Needs Assessment  
 Clinic

- Persistent +/- significant recurrent exacerbations
- Notable functional restriction/limitations
- Persistent sick leave

Major motor deficit (MRC grade 3 or less)  
 Progressive neurological deficit  
**URGENT APPOINTMENT 48 HRS (MRI, X-RAY)**

**ICATS FACE TO FACE CLINICS (Adults Only)**  
 Assessment, diagnosis, management, reassurance  
 Onward referral to consultant team with 'work up' where necessary to include MRI, X-Ray, Blood tests as necessary

Discuss with on call spinal team at ROH prior to referral

**Pain Clinic**  
**Pain management**

**SPINAL SURGICAL CLINIC**

Potential surgical candidate\* and patient prepared to consider surgery

**Other non-spinal services** e.g. rheumatology, oncology

- \* Surgical candidates
- Patients with less than 6 week history of spine related symptoms without red flags seldom require surgical opinions
  - Degenerative neck pain is not normally treated by any form of surgery. Surgical opinion is only warranted if concern regarding potential cervical myelopathy
  - Patients previously assessed and deemed unsuitable should not be re-referred unless there has been a significant change in pain pattern, character or objective neurological deterioration

## Explanatory Notes

- The flow chart is designed to give clinicians (GPs and Physiotherapists) an 'at a glance' look at the referral and management pathway for patients with low back pain and referred leg pain, to OPS. It can also apply to \*cervical and arm pain - the same principles apply, that if progressive upper limb neurological deficit is encountered, then the onward referral process can follow similar routes. The chart is designed to follow the four scenarios of acute back pain, chronic back pain (both of which can include referred leg pain), and where leg pain predominates the symptomology (radicular or stenotic pain), and Red Flags. This then allows clinicians to 'signpost' to the appropriate pathway. Please note that back pain whether acute or chronic can present with somatic referred leg pain, and unless a trial of conservative physiotherapy has been made, then these patients should first be referred to physiotherapy. If this has failed or the back/leg pain 'picture' is too severe then refer to the OPS.
- It is important to note that triage and assessment for spinal pain is a multi - dimensional problem, involving both physical and psychosocial characteristics, so the chart is a guide and no substitute for sound clinical reasoning and flexibility in each individual patient case. Also onward referral to the surgical team is only appropriate if the patient is willing to consider surgery. Referral on to the surgical team for discussion on surgery is appropriate in cases where the patient is undecided, but there are clear clinical reasons for surgery
- It is important for clinicians to be able to differentiate between true radicular pain from probable disc protrusion (and more likely to respond to surgical input), and somatic referred pain that can arise from many other pain generating structures within the spine. Although both states can combine in a patient, differentiation is important. The following chart for identifying symptomatic disc herniation with nerve root involvement may be useful:

RADICULAR SYMPTOMS/SIGNS	SOMATIC SYMPTOMS/SIGNS
<ul style="list-style-type: none"> <li>• Unilateral leg/arm pain in a typical sciatic root distribution below the knee (severe and shooting often felt along a narrow strip)</li> <li>• Specific limitation of straight leg raising by at least 50% of normal, with reproduction of leg pain</li> <li>• Segmental motor deficit</li> <li>• Segmental sensory change</li> <li>• Hyporeflexia</li> <li>• Acute Kyphotic/and or scoliotic deformity</li> <li>• Imaging evidence of a disc protrusion at the relevant level</li> </ul>	<ul style="list-style-type: none"> <li>• Vague, deep, dull aching, difficult to localise the source</li> <li>• Felt more closely related to the myotomes rather than dermatomes</li> <li>• Straight leg raise normal</li> <li>• No segmental motor deficit</li> <li>• No segmental sensory deficit</li> <li>• Normal reflexes</li> <li>• No acute deformity</li> </ul>

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Porter RW and Miller CG (1986) back pain and trunk list. Spine 11.596-599Kramer J (1990) Intervertebral disc diseases. Causes, Diagnosis, Treatment and Prophylaxis (2<sup>nd</sup> ed.) Thieme Medical Publishers NY

McKenzie and May (2003) The Lumbar Spine Mechanical Diagnosis and Therapy Spinal Publications NZ

Grainger M (2004) SWPCT Guidelines for Back Pain Management/Referral

Prodigy – Practical support for Clinical Governance

Waddell G et al. (1999) Low back Pain evidence review. London: Royal College of General Practitioners

Waddell G (2004) The Back Pain Revolution Churchill Livingstone

# ICATS Clinical Knee Pathway

## CONDITIONS SUITABLE FOR CONSULTANT REFERRAL

Patient presents with:

- Major degenerative changes
- Gross traumatic instability
- Inflammatory knee pain
- Evidence of knee haemarthrosis
- Locked Knee
- Patients already under consultant care
- Recent knee surgery
- Primary Dislocation Patella
- Acute meniscal tear
- Paediatrics under 12

Acute injury consider urgent referral to A&E/# clinic

## ICATS TRIAGE

## CONDITIONS SUITABLE FOR FACE TO FACE ICATS FOLLOWING FAILED PHYSIOHERAPY TREATMENT

Patient presents with:

- Non-traumatic instability
- Recurrent subluxation/dislocation patella
- Anterior knee pain
- Mild to moderate degenerative changes
- Degenerative meniscal tear
- Chronic ligament insufficiency
- Non specific knee pain
- Previous physiotherapy unsuccessful and unsuitable/does not want surgery
- Complex soft tissue pathology

**Orthopaedic Consultant**

**Physiotherapy**

Discharge

## ICATS FACE TO FACE CLINICS

Assessment, diagnosis, management –  
Onward referral to consultant team with 'work up' where necessary to include MRI, X-Ray, Blood tests as necessary

Onward Referral to Podiatry/Orthotics

Patient Self management

Full report to GP  
Future plan of management

Discharge

**ICATS Clinical Shoulder Pathway**

**ICATS TRIAGE**

Acute injury consider urgent referral to A&E/# clinic

**CONDITIONS SUITABLE FOR CONSULTANT REFERRAL**

- Primary traumatic instability
- Definite rotator cuff tear
- Patient already under care of orthopaedic consultant
- Patients requesting a second consultant opinion.
- Paediatrics <18 years
- Major degenerative changes.
- Acute injuries.

**CONDITIONS SUITABLE FOR FACE TO FACE ICATS FOLLOWING FAILED PHYSIOHERAPY TREATMENT**

- Non traumatic instability
- Complex soft tissue pathology
  - impingements
  - frozen shoulder
  - capsulitis
- Mild to moderate degenerative changes
- Non specific shoulder pain
- Acromioclavicular joint pathology
- Previous unsuccessful conservative treatment unsuitable/does not want surgery

**ICATS FACE TO FACE CLINICS** Assessment, diagnosis, management  
Onward referral to consultant team with 'work up' where necessary to include MRI, X-Ray, Blood tests as necessary

**Orthopaedic Consultant**

**Physiotherapy**

Discharge

Full report to GP, Future plan of management

**Patient Self management**

Discharge

## ICATS CLINICAL PODIATRY PATHWAY

### ICATS TRIAGE REFERRAL AFTER FAILED CARE THROUGH ROUTINE PODIATRY

#### CRITERIA FOR REFERRAL TO PODIATRY ICATS

- Heel Pain – Plantar Fasciitis
- Metatarsalgia – Forefoot Pain
- Capsulitis/capsular tear/flexor tenosynovitis
- Stress/March fracture
- Sesamoiditis
- Hallux Limitus/Rigidous
- Posterior Tibial tendonitis Dysfunction
- Posterior Heel Pain
- Retrocalcaneal Bursitis
- Tarsal tunnel syndrome
- Toe deformities
- Pes planus/cavus
- Mechanical joint pain
- Non-specific foot or ankle pain

#### SUITABLE FOR REFERRAL TO CONSULTANT TEAM

- Patients already under the care of a Consultant
- Patients under 18.
- Immediate surgery required
- Previous Surgery
- Suspected fracture/subluxation
- Definitive Tendon Rupture e.g. Tendo Achilles
- Systemic Symptoms e.g. inflammatory joint disease
- Failure of Injection Therapy

### ICATS CLINICAL PATHWAY HANDS

Conditions	Relevant signs & symptoms	Refer to Physiotherapy	Refer to OPS	Refer to consultant
Boutonniere deformity.	Loss of active ext PIPJ, possible hyperextension at DIPJ, swollen PIPJ.	No	Yes	No
Cervical spine related symptoms referred to upper limb	Stiff or painful neck with pain and/or paraesthesia in upper limb	Yes	No	No
Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy/Algodystrophy	Following trauma or surgery, patient complains of disproportionate pain, skin temperature and/or colour changes, swelling, stiffness	Yes	If no response to Physio	OPS will refer as required
CTS	Paraesthesia, numbness thumb, index, middle and radial side ring finger, clumsy hand, nocturnal symptoms.	Early onset, no neurological changes	If no improvement with Physio	No
Dupuytren's disease	Bands/nodules in palmar fascia, flexion deformities of digit/s	No	Yes	If flexion contracture at any joint exceeds 30 degrees
Ganglia	Transluminant lump often dorsal or volar wrist or palmar aspect of fingers (seed ganglia), may increase and decrease in size	No	No	If symptomatic and patient requesting surgery
Inflammatory arthritis	Pain or reduced range of motion or deformity affecting hand function.	If function/ ROM deteriorating, medically well controlled	If no improvement with Physio Pain main complaint	OPS will refer as required
Mallet finger with/without Swan neck deformity	Inability to extend DIP joint actively.	First choice closed injury	If no improvement with Physio	No
Mucus cysts	Firm lump at DIPJ, may ooze jelly-like fluid	No	No	If symptomatic and patient requesting surgery

Non-specific wrist or hand pain	May be associated with Diabetes, thyroid dysfunction, previous trauma, pre clinical CTS or flexor synovitis	Yes	If no improvement with Physio	Will be referred by OPS if required
Osteoarthritis of the CMCJ of the thumb	Pain at base of thumb on or after pinch grip activities	Early onset symptoms	If no improvement with Physio	If no improvement with previous interventions, patient would consider HCl or surgery
Osteoarthritis fingers	Pain, reduced range of motion or deformity affecting hand function.	Yes	No improvement with Physio	OPS will refer as required
Residual problems post hand trauma e.g. crush injuries, dislocations.	Oedema and reduced ROM of MCPJ/S, PIP/Js or DIPJ/s. Joint contractures. Slow to return to work/function.	Yes	If no improvement with Physio	No
Scar hypersensitivity or hypertrophy following lacerations, burns or previous surgery.	Light touch or pressure causes disproportionate pain or scar causes restricted range of motion.	No	Yes	No
Tenosynovitis, de Quervain's disease	Wrist or thumb pain on pinching or gripping and on resisted abductions, tendon crepitus, local swelling and tenderness	Yes	No improvement with Physio	If no improvement with previous interventions, patient would consider HCl or surgery
Trigger finger/thumb	Finger or thumb becomes stuck in flexion on gripping	No	No	Yes if patient would consider HCl or surgery
Ulnar neuritis	Paraesthesia in little and ring fingers, aggravated by full elbow flexion, +ve Tinel's tap over nerve posterior to medial epicondyle elbow.	No	Yes	OPS will refer if required
Work related upper limb dysfunction, RSI	Varied, often diffuse with nil to see, poor function. May include CTS and/or tendinitis	Yes	If no improvement with Physio	No

**ORTHOPAEDIC PRACTITIONER SERVICE  
USEFUL CONTACT TELEPHONE NUMBERS**

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*\*Contents this document are subject to change without notice*