NHS England

Clinically-led Spinal Surgery & Spinal Pain Outpatient Guidance

Practical OPD guidance for Spinal Surgery & Spinal Pain services to maximise efficiency and reduce waiting times for patients

July 2023

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Acknowledgements: Clinically-led Specialty Outpatient Guidance

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Acknowledgements: Clinically-led Specialty Outpatient Guidance

GIRFT and OPRT are very grateful for the input and support from the following organisations in the development of this guide:

Society of British Neurological Surgeons

Foreword and contents: Clinically-led Specialty Outpatient Guidance

The Getting It Right First Time (GIRFT) and Outpatient Recovery and Transformation Programme (OPRT) teams have produced this guide which outlines actions services can take to tackle escalating demand for outpatient appointments. It provides practical, condition-specific advice for services to focus on which are safe and clinically appropriate for specialities with the highest number of +78 week waits[1].

Aimed at clinicians and operational teams, actions are highlighted for each service to drive quality improvement within outpatient provision. Readers should evaluate their service against the guidance set out and work towards implementing any gaps. Within each section, links to further guidance and resources can be found using the resources links.

This document should be used as template for standardisation of clinical prioritisation, optimising outpatient capacity and resources in outpatients to improve patient pathways and experience.

Further information from GIRFT and OPRT can be found here:
Getting It Right First Time - FutureNHS Collaboration Platform
Outpatient Recovery and Transformation Platform - FutureNHS Collaboration Platform

[1] as of August 2022

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Actions for outpatient waiting lists: Clinically-led Specialty Outpatient Guidance

Action for non-admitted waiting list – new patients

Clinical staff to triage new patient referrals:

- ☑ Is the patient on the right pathway?
- ☑ Can diagnostics be undertaken prior to first appointment or a one stop clinic visit?
- ☑ If the patient needs to be seen, how should the patient be seen?
  - ☑ Telephone, video or face to face?
  - ☑ Who should see the patient - consultant or other member of medical team, nurse specialist, physiotherapist etc?
  - ☑ Once seen, can they be discharged back to GP or moved to PIFU if clinically appropriate?

Action for non-admitted and non-RTT waiting list – follow-up patients

Clinical staff to validate follow-up lists (post-diagnostics):

- ☑ Does the patient need a follow up, or can they be discharged with letter to patient and GP?
- ☑ If the patient needs to be seen, how should the patient be seen?
  - ☑ Telephone, video or face to face?
  - ☑ Who should see the patient - consultant or other member of medical team, nurse specialist, physiotherapist etc?
  - ☑ Once seen, if no further treatment indicated, can the patient be discharged back to GP or moved to PIFU if clinically appropriate?

Actions for the admitted waiting list

- ☑ Clinically review those waiting >1 year, as to whether an intervention is still needed.
- ☑ Day case by default clinical policy.
- ☑ 85% of elective procedures (with minimal exceptions e.g. arthroplasty) delivered as day case.
- ☑ Maximise existing theatre sessions that are staffed and run. Achieve 85% theatre capped utilisation time.
- ☑ Maximise "Right procedure Right place" – moving appropriate procedures into procedure rooms.
- ☑ Develop surgical hub sites - 91 existing & over 50 new hubs, working at GIRFT standards.

Specialty specific actions can be found on the relevant specialty page

Background on outpatient waiting lists: Clinically-led Specialty Outpatient Guidance

In 2021/22, the NHS delivered **95 million outpatient appointments** – almost 2 million appointments per week.

As at Feb 2023 there were **7.22 million patients waiting to start treatment**:

- **6.12 million on a non-admitted pathway**
- 1.10 million on an admitted pathway – waiting for a procedure
- 30,000* patients are waiting over 78 weeks on an open RTT pathway
    - Approx 50% of these (c.15,000) have a decision to admit

The remaining outpatient capacity is used for non-RTT follow ups. 12 specialties have greatest number of patients in this category which are included in this guide. Actions highlighted in this document should become standard practice in managing outpatients.

* October 2022 RTT estimate

Appointments lost to DNAs

- The number of DNAs recorded in HES data for 2021/22 was 7.8 million*
- This is equivalent to around 8% of the total 95 million outpatient appointments actually attended in the same period
- A 25% reduction in these DNAs would release the equivalent of almost 2 million appointments – potentially enough to clear the entire +78 and +40 week non-admitted RTT backlog.

*taken from HES data 2021/22, likely understates the true position.

Total OP Appts Attended vs. DNAs reported, 2021/22

Standardising follow-ups and increasing levels of safe discharge will:

- Support a timely and better experience for patients.
- Improve patient flows for patients awaiting treatment and those on long term monitoring.
- Free up valuable diagnostics.
- Improve the clinic experience for clinicians, nursing staff and all allied health professionals.
- Improve training experience for trainees.
- Release surgical time/expertise for theatres, ward rounds and training.

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Patient View – what matters to me?: Clinically-led Specialty Outpatient Guidance

Listening to people who are living with ill health, and to those who are using services is never the wrong thing to do.

We all want to receive communication about our health in a way that suits us and in a way that helps us to make informed choices.

If we can get things right for people with sensory impairments, for people with low literacy and people who speak English at various degrees of fluency, it will make health and care better for all of us.

It's time to put patient choice, [needs] and personalisation at the heart of all NHS communications.

Sarah Sweeney
Head of Policy, National Voices (HSJ, 2022)

Patients ask us to:

- Make every contact count
- Reduce visits to hospital
- Consider rising cost of living
- Avoid travel and other costs
- Consider how we can tailor our communication and support for different communities

We need to:

- Design services around patient need – at convenient times, locations etc.
- Take into consideration the needs of patients i.e. physical and mental needs, cultural and social-demographic factors
- Personalise care, giving patients choice and control over their healthcare
- Review referrals at the earliest opportunity to minimise wasted time for patients
- Discharge patients when clinically appropriate to free up capacity for new patients and those waiting to be seen
- Ensure all communication with and about patients conforms with the Accessible Information standard

We need to transform outpatient services for the benefit of our patients

Specialist Advice: Clinically-led Specialty Outpatient Guidance

Specialist Advice is an umbrella term for a range of models that facilitate a clinical dialogue between a specialist and referrer prior to, instead of, or about a referral to support the management of patient care.

This can be:

- **Pre-Referral (e.g. Advice & Guidance):** prior to or instead of referral the referring clinician seeks advice from a specialist through synchronous or asynchronous methods.
- **Post Referral (e.g. Referral Triage models that offer Specialist Advice):** where a referral has already been made, the specialist reviews the information, and can either return the referral with guidance or direct the onward referral to the most appropriate clinician, clinic and/or diagnostic pathway.

Reasons for seeking specialist advice

- ☑ Advice on a treatment plan and/or the ongoing management of a patient
- ☑ Clarification (or advice) regarding a patient's test results
- ☑ Advice on the appropriateness of a referral for a patient

Who can provide specialist advice?

- ☑ Trained and commissioned clinical specialists / experts
- ☑ Consultants
- ☑ SAS Doctors
- ☑ Other healthcare professionals in secondary, community or primary care providers, interface or intermediate services, and referral management systems

Benefits of specialist advice

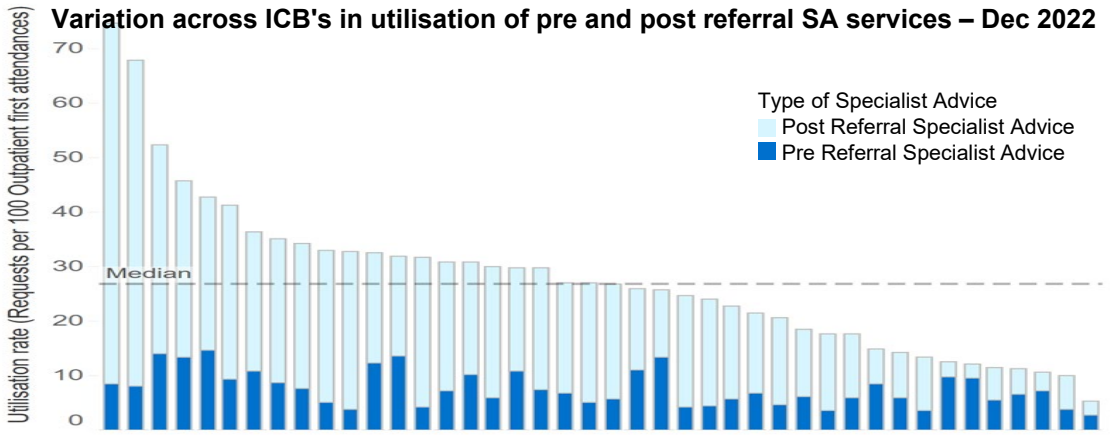
- ☑ Improved patient experience
- ☑ Enables quicker access to the right care and investigations, closer to home
- ☑ Supports shared decision making
- ☑ Collaborative working
- ☑ Sustainable model of care
- ☑ Efficient use of resources

Resource links

OPRT Specialist Advice FAQs

OPRT Introduction to Specialist Advice

Variation across ICB's in utilisation of pre and post referral SA services – Dec 2022



National Picture

- Historically, use of specialist advice was variable across England so a planning guidance target was set for each system to reach 16 advice and guidance requests or equivalent models per 100 OPFA by March 2023.
- This was with the aim of avoiding 1.8 million RTT clock starts in 2023 and is incentivised by Elective Recovery Fund payments.
- Specialist advice utilisation has grown nationally with 75% of systems now reaching the planning target of 16 per 100 OPFA . Pre referral services (A&G type services) account for a third of requests.
- The proportion of requests resulting in an avoided referral (diversion rate) differs greatly between pre referral type services (50%) and post referral type services (15%).

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Reducing ‘Did Not Attends’ (DNAs): Clinically-led Specialty Outpatient Guidance

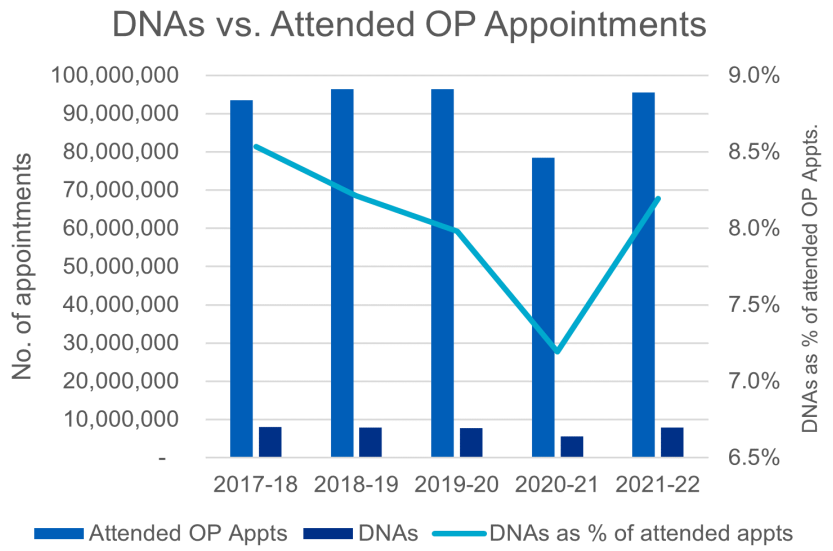
There were 95.6 million attended outpatient appointments in 2021/22. and 7.8 million DNAs. This equates to an average of around 650,000 monthly appointment slots being lost due to missed appointments. This valuable clinical capacity could be used to see other patients, including those who have been waiting for care the longest and those with the most clinically urgent conditions.

Key actions providers can take to help with DNAs are:

- **Send appointment reminders to patients – including letters, emails, SMS and phone call reminders**. This can reduce DNAs by up to 80% and works better when communication is “two way” (patients also prefer this). Organisations should ensure appointment letters and reminders are written in simple language and are accessible to the individual patient.
  - **Information should include: what the appointment is for, with what service and have service contact details.**
  - Review the intervals and frequency of reminder emails and SMS.
  - Ensure hospital maps are clear in letters and emails, and signage in the hospital matches this.
- **Ensure material is health literate to improve communication and access for cancellations and re-booking** to ensure patients can cancel / rearrange appointments easily.
- People in marginalised groups are generally more likely to miss their appointments**. Work with public health colleagues locally to understand what can be done to support patients that are more likely to DNA e.g.**
  - Why higher levels of deprivation might be increase DNAs e.g. transport costs, notice to take day off work or arrange carer for dependants etc.
  - How ethnic and cultural differences might affect attitudes to attendance
  - Ensuring translations are available in languages of all local minority groups
  - Considering additional needs of people with autism or learning disabilities
- **Improve booking processes/standardisation -** consider offering evening/weekend appointments.
- **DNA audits to identify potential causes.**

Key actions providers can take to help reduce impact of DNAs:

- Review the DNA patient's notes and attempt to contact remotely or write with the next steps.
- Implement a “short notice list” – so that any last-minute cancellations can be used by people who are able to attend without advanced warning, e.g. hospital staff, local patients
- Use clinical time lost to DNA for other high priority activities, e.g.:
  - Respond to requests for specialist advice/triage of new referrals, waiting list validation etc.;
  - waiting list validation;
  - review patient notes for people booked into future clinics to see if those appointments are still needed;
- Overbook outpatient clinics where DNAs are frequent and more likely.



Appointments lost to DNAs

A **25% reduction in these DNAs** would release the equivalent of almost **2 million appointments** – potentially enough to clear the entire +78 and +40 week non-admitted RTT backlog

Resource links

OPRT Reducing DNAs in outpatient services

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Remote Consultations: Clinically-led Specialty Outpatient Guidance

Remote consultations played an important role in the NHS' response to the COVID-19 pandemic, helping hospitals and clinics reduce the number of physical attendances at their sites. Nearly 25% of all outpatient appointments are now being held remotely, the pandemic proving that remote consultations are a safe and effective way of delivering patient care. Video consultations saved patients more than 530 years of time and £40m in travel costs in 2020/21 alone, also reducing carbon footprint and supporting the Greener NHS agenda. In conjunction with video consultations, online forms can support the NHS in tackling the backlog of elective care, by contributing to the reduction of waiting lists through freeing up clinician and administration time and supporting more flexible and personalised channels to delivering care.

A **remote consultation** is a consultation that takes place digitally over the **telephone, video, online form, or through asynchronous messaging** as opposed to face-to-face.

The decision on whether an appointment will take place remotely should always be clinically-led and based on individual care needs and preferences. If a remote consultation is clinically appropriate, it should always be the patient's choice whether to accept the remote consultation using shared decision making conversation with the clinician.

Benefits of remote consultations:

- Improves patient's experiences of care, improving access through increased flexibility in how they interact with healthcare, saving them time and money and reducing the stress of travelling to their appointments.
  - 68% of patients would be comfortable with a remote consultation (ONS, 2020).
  - Average journey time to and from a hospital appointment is 48 minutes (EdgeHealth, 2021).
- Patients are less likely to cancel or not attend their appointments (EdgeHealth, 2021).
- Remote consultations also offer benefits for healthcare professionals, reducing travel time and stress, and enabling more flexible working, meaning more time to spend with patients.

Selecting patients:

- Do you feel your patient/service user would be suitable for a remote consultation (telephone, video consultation or online form)?
- Does the patient/service user require physical examination and/or additional diagnostic tests that mean a physical consultation is necessary?
- Does the patient/service user have access to the right equipment/appropriate help to effectively use remote consultation tools?
- Are there clinical benefits to consulting with the patient/service user remotely – for example, infection prevention and control, lower levels of anxiety for the patient/service user, improved access to NHS services, access to an MDT when staff are not co-located.
- Are there other benefits to the patient/service user – for example, reduced travel requirements, ability to include family or friends in the consultation who are not co-located with the patient/service user.
- Is the patient/service user comfortable (or likely to be comfortable) with the concept of a remote consultation?
- Is this appropriate for this patient considering needs e.g., language, disability etc.
- Is the patient's preference regarding remote consultations recorded in the patient/service user's personalised care and support plan (PCSP)?

Resource links

- OPRT Video consultation Information for Trusts
- OPRT Choosing how to consult with your secondary care patients
- OPRT Video consulting with your patients – a quick guide for NHS staff
- OPRT Video consulting with your NHS – a quick guide for patients
- OPRT Template Video Consultation SOP

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Patient Initiated Follow-up (PIFU): Clinically-led Specialty Outpatient Guidance

Patient initiated follow-up (PIFU) is a system that enables a patient or their carer to initiate a follow-up appointment when they need one (e.g. due to a change in symptoms or circumstances). PIFU **should not be used** in place of discharging patients appropriately.

This helps patients to be seen quickly when required, while avoiding the inconvenience of appointments they don't need.

Most patients come back less often when using PIFU. This creates capacity to see other patients from the waiting list.

Shared decision making between a patient and clinician ensures PIFU is only used for those who are suited to it.

Safety nets should be used to ensure:

- Appropriate review still takes place, if and when required;
- DNA processes are put in place for those on PIFU;
- Relevant diagnostics still occur at the right intervals;
- The patient is able to manage this process.

PIFU **arrangements should be communicated** in a letter to the patient, and copied to the GP, with clear actions noted for the GP as appropriate.

Resource links

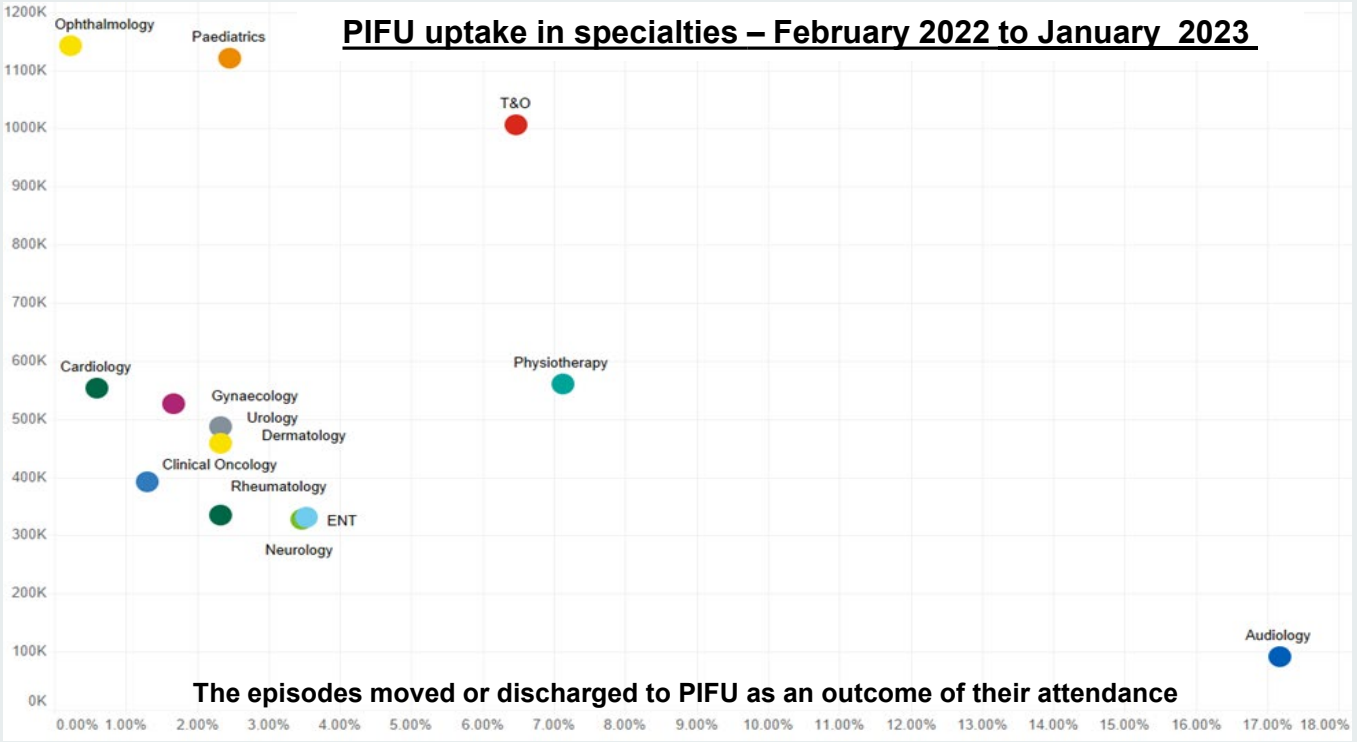
- OPRT PIFU Guidance
- Shared decision making Guidance
- OPRT PIFU implementation plan and checklist
- OPRT Template PIFU SOP

PIFU can be used:

- ☑ After treatment
- ☑ After surgery
- ☑ People with long term conditions
- ☑ Alongside time appointments e.g. for tests
- ☑ Alongside remote consultations
- ☑ Patients can share responsibility with a carer or guardian

Minimum quality standards for PIFU

- ☑ All patients and/or carers should have a shared decision making conversation where PIFU explained to them, and they have the opportunity to ask questions and raise concerns. If they do not understand how or when to trigger an appointment, PIFU should not be used (see resource information on **shared decision-making**).
- ☑ A standard operating procedure (SOP) that includes patient safety nets (giving rapid access back to specialist care if needed) should be in place.
- ☑ Patients moved to PIFU pathways should be tracked on the provider's IT system and clinical records.
- ☑ Services should report and monitor key PIFU metrics e.g. number of patients who are on a PIFU pathways



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Latest Clinically Appropriate Date (LCAD): Clinically-led Specialty Outpatient Guidance

Why LCAD is important

When used effectively, LCAD is a powerful tool for understanding demand and enables safer management of patients who need following up in outpatients:

- LCAD captures the clinician's view on the latest date by which the patient should be followed up, in order to maintain a reasonable margin of clinical safety.
- Where completed in PAS systems, this data is collected as part of the Commissioning Data Set (CDS). However, the LCAD field needs to be enabled within the provider's patient administration system (PAS) system to allow data collection.

Collection and submission of LCAD is required but not mandated, therefore **at present there is considerable variation in submission of this data**, making analysis of future follow-up demand data difficult (as it is not reported nationally).

In contrast, new patient (18 weeks or RTT) data is mandated and collected nationally, with clear targets, validation and performance reporting. This disparity can lead to inequity in access to treatment, and can have an adverse effect on patient outcomes if RTT waiting times overshadow follow-up lists.

Consistent and accurate recording/reporting of LCAD enables the measurement of future follow up demand, which will guide mitigating actions to prioritise patients.

Resources

NHS Data Model & Dictionary

Benefits of LCAD
Enables providers to define the demand for follow up to enable **effective capacity planning**
To **understand follow up demand, and follow up backlogs, because they pose a greater risk of unwarranted avoidable harm (e.g., permanent sight loss) to patients whose care is delayed**
Used in conjunction with **clinical risk stratification** to differentiate and help prioritise options and resources for high, medium and low risk patients. It is an essential part of **failsafe** framework
Optimise clinical outcomes for patients by **reducing the risk of avoidable patient harm due to delayed follow up**
Minimise litigation risks and subsequent cost of claims for avoidable harm or negligence

The non-RTT follow-up backlog

- **Follows ups make up more than two thirds of delivered OP activity (65m of 95m appointments).**
- Non-RTT follow-ups are the least visible part of outpatient activity because it is not mandated to report this activity at local or national level.
- Using LCAD is a **data driven approach to understand the hidden or unreported demand for follow up**.
- **LCAD enables better management of follow-ups, and means risks can be identified and mitigated earlier** to avoid patients coming to harm.

MANAGEMENT ACTION:

- Ensure PAS system has a functional LCAD field which can be extracted for the CDS version 6.3.
- Use the adoption of CDS6.3 to optimise LCAD data flow.
- Encourage cultural and process ownership.

CLINICIAN ACTION:

- Promote the understanding of LCAD's relevance to identifying risk and reducing harm linked to follow up back log.
- Promote the relevance of LCAD in identifying unwarranted variation within the system and region.
- Promote the usefulness of LCAD in identifying opportunities for mutual aid within systems.

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Outpatient Clinic Letters: Clinically-led Specialty Outpatient Guidance

Letters following an outpatient appointment form an integral part of an outpatient attendance, providing valuable information on the consultation and the plan for the patient's ongoing management. They enable continuity of care within the provider, and as care is transferred/shared with colleagues in other specialities and primary care.

Outpatient clinic letters have at least three different audiences, each of which will have different requirements for what they need to be able to take from the contents. In view of this clinic letters must be clear, concise, in plain English and be structured with headings to allow quick and easy reference for all concerned. For patients , there should be an appreciation of their needs by considering adaptations e.g. those with visual impairment needing larger text in line with Accessible Information standard

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	Patient / Carers	Primary Care	Secondary / Tertiary Care
Requirements	Patients often won't remember all that is discussed in clinic. The letter serves as a summary of their consultation to act as a reminder of what was discussed and what they can expect to happen next, or what they may need to do	In view of the high volume of letters these are primarily dealt with by admin, coders and pharmacy. Need to easily understand and identify information on any changes to the patient's diagnosis or management and any actions required by primary care	A summary of the care received to date and the patient's relevant history with a clear plan for the ongoing management to ensure that if the patient is seen by a different healthcare professional they are able to provide good continuity
Key Features	• Letter written to patient with a copy to other healthcare professionals • Avoidance of medical jargon and acronyms, ensuring patients / carers can understand the information • Clearly highlighting actions that they need to undertake and any follow up • Contact details for any later queries	Summary of the key information that is structured and in plain English: • Diagnoses (highlight any new ones) • Changes to medication • Planned Investigations • Management Plan (who is responsible) • Actions for Primary Care to arrange • Any follow up or escalation plan • Contact details for queries / escalation	• Significant past medical history (if not easily accessible through the electronic health record) • Treatment Summary • Management Plan • Next steps for escalation • Any plans for follow up

Resource links AOMRC – Guidance for outpatient clinic letters

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Spinal Surgery & Spinal Pain: Clinically-led Specialty Outpatient Guidance

Community access to diagnostics

Diagnostics within the community can be requested by **MSK practitioners with spinal expertise**, **who attend the virtual triage review routinely** and are active within system spinal services. MRI is rarely indicated for isolated back or neck pain and should only be organised after assessment by a musculoskeletal practitioner with spinal expertise.

MSK practitioners with spinal expertise, sit in primary and / or community care (with clinical governance integrated through local spinal services) and they attend the virtual spinal triage reviews.

Virtual triage review

After a patient has had a comprehensive assessment in the community or primary care setting by an **MSK Practitioner with spinal expertise**, their notes can be brought for virtual clinical review, with the outcomes of either referral to secondary care or care continuing in the community.

Minimum quorate attendance; MSK Practitioner/s with spinal expertise, Spinal Surgeon, Pain consultant, Admin support.

See **Resource Links** for referral triage case studies.

Validation of all outpatients waiting (especially non-RTT, follow-ups)

The entire patient list should be clinically reviewed regularly by an appropriate clinician to ensure patients are on the right pathway and still need to be seen:

Review	Validation Action
Patients waiting more than 12wks for 1st appt	Letter or call to patient to ask if they still have symptoms and still want to be seen (removing from list, as appropriate). Patients can be signposted to pages such as BASS , CSP, BPS as appropriate.
Is patient suitable for discharge without follow up?	Call with patient to explain why they no longer need to be seen and can be discharged
Suitable for PIFU (patients that have been treated)?	Remote appt. with patient to have shared decision making discussion about PIFU and its suitability for them, ensuring they understand when and how to seek further support
Follow up appt. required	Offer remote appointment unless F2F is required (*see 'post-op review' box)*

Consent by telephone appt. saving appointment slots

Progress consenting for treatment **via telephone,** provided that the patient has previously had a face-to-face appointment with the operating team at which the procedure was discussed; along with shared decision making conversations making treatment, care and support options explicit (including 'do nothing') and providing evidence based information on outcomes benefits & risks associated with these.

Post-op Review (Follow Up)

In the Spinal HVLC pathways, the following post-operative pathway is recommended:

Pathway	Time frame post-op	With	How
One or Two level posterior fusion surgery (PLF/LIF/PLIF)	6-8wks	Surgical team	Face to Face
One or Two level anterior cervical discectomy & fusion/disc replacement, posterior cervical foraminotomy	6-8wks	Surgical team	Face to Face
Posterior lumbar decompression/discectomy	6-8wks	Surgical team	Telephone call
Lumbar nerve root block/epidural	6wks	MSK practitioner	Telephone call
Lower lumbar medical branch block/facet joint injections	3wks	Pain team	Telephone call

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Spinal Surgery & Spinal Pain: Clinically-led Specialty Outpatient Guidance

Patient Initiated Follow-Up (PIFU)

When it is agreed that the patient will move onto a PIFU pathway, this should have an agreed timeframe.

If the patient makes contact during this time, they should be offered a telephone triage appointment.

Pathway	PIFU time to discharge
Lumbar decompression/discectomy	6 months
Lumbar nerve root block/epidural	
Medial branch block/facet joint injections	
Persistent pain after sustaining a recent stable thoracolumbar fracture	
Stable symptoms in cases of known spinal stenosis	
Patients unsure whether they want a spinal procedure	
ACDF/CDR/Posterior cervical foraminotomy	12 months
One or two level fusion	

DNAs

It is important for services to have an understanding of their DNA rates in outpatients. Providers and Systems will have 'reminder' services via telephone, text message, email or similar that are in place. Providers will have their own Access Policies covering their management of DNAs. The following can be considered for management of spinal and pain patients who do not attend their appointment:

- After a single DNA, contact the patient via letter (with a copy to the GP) or telephone asking them to get in touch if they want to make another appointment, and the provider will reinstate it.
- Following 2 failed attendances, patients should be discharged back to their GP.

Optimal number of outpatient attendances

Model health system (see **Resource Links**) shows providers and systems performance in a range of metrics. In spinal surgery and spinal pain, this also includes a benchmark for:

Pathway	Benchmark number of outpatient appts pre-surgery	Benchmark number of outpatient appts post-surgery
Anterior cervical discectomy, disc replacement or decompression/fusion	2	2
Posterior lumbar decompression	2	1

Resource links

- Model Health System
- OPRT Implementing PIFU in Adult Spinal
- GIRFT Spinal Pathways
- BestMSK Virtual triage review case studies
- GIRFT Spinal National Report
- Best MSK Decision Support Aids
- BestMSK Spinal MRI clinician & patient advice
- Shared Decision Making

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Spinal Surgery & Spinal Pain: Clinically-led Specialty Outpatient Guidance

Top tips for Spinal services:

- Shared Decision making principles should be followed and all opportunities for supported self-management utilised throughout the patient pathway
- Encourage best use of MSK practitioners with spinal expertise in primary and community care in first contact and/or community roles for shared decision making re diagnostic imaging and onward referral
- Clinical teams in providers and systems should engage with Virtual Triage Review of patients – 1 PA per week for Spinal consultants
- Review and follow the HVLC pathways for spinal surgery & spinal pain, including timeframes and locations of follow-up appointments
- Ensure standardisation of follow up processes within teams
- Validation actions with a focus on patients who have been on the non-admitted pathways for longer than 12 weeks
- Review and challenge provider-level outpatient performance on Model Health System
- Utilise PIFU when clinically appropriate ; review and close PIFU pathways in a timely manner
- Administrative support should be provided for Virtual Triage and PIFU
- Implement guidelines on pathways and audit efficacy of interventions