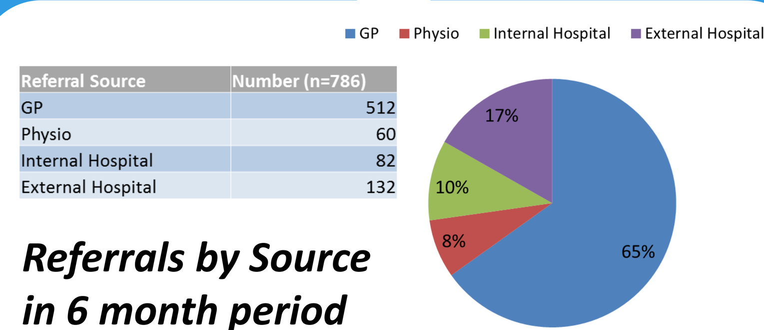
The Leeds Teaching Hospitals NHS
NHS Trust

The Leeds Elective Spinal Triage Service

Re-shaping Elective Spinal Referral Pathways at Leeds General Infirmary

Problem

Prior to our intervention the Leeds Spinal Service took elective referrals from General Practice and these were added to a waiting list to be seen. We identified a number of problems with the elective spinal referrals service; not least there were concerns around patient safety as the system was overloaded and the time taken to see patients in clinic was long resulting in delays to treatment. There were also concerns that some patients who may have best been seen through our emergency referral service were inappropriately referred to the elective service.



Referral Source	Number (n=786)
GP	512
Physio	60
Internal Hospital	82
External Hospital	132

Referrals by Source in 6 month period

Assessment

The elective orthopaedic spinal service is referred around ***1500 referrals per year*** from various sources, the majority (65%) from GPs. There had been a progressive increase in the waiting times during the previous years to the extent that 18 week wait targets were not being met. This drove the need for a new strategy to reduce waiting times while ensuring safe provision of the service.

Strategy

The process started following DoH recommendations for the introduction of spinal referral triage services[1]. At the same time the trust introduced a policy to allow GPs to access MRI from the community that we found could facilitate this new service which meant we could introduce the necessity for patients to have scans done before being seen in clinic. The method of referral remained the same from a GP perspective. The aims were to develop a one-stop appointment: history , examination, investigations, diagnosis and plan at the first appointment. This would ensure patients were directed to the correct resource and reduce unnecessary follow-up appointments.

Triage also meant that often patients could be referred and seen directly by other specialities such as MSK physicians, physiotherapy or radiology services without being seen first in a dedicated spinal clinic. There were some obvious risks identified for example, there may be important information missing from the GP letter, investigation results may not be available and scans reviewed in triage meetings may not be representative of pathology. There was also a risk that GPs may inappropriately refer urgent cases via the elective system. To avoid these, appropriate 'safety nets' were included in the triage system to catch those either inappropriately referred.

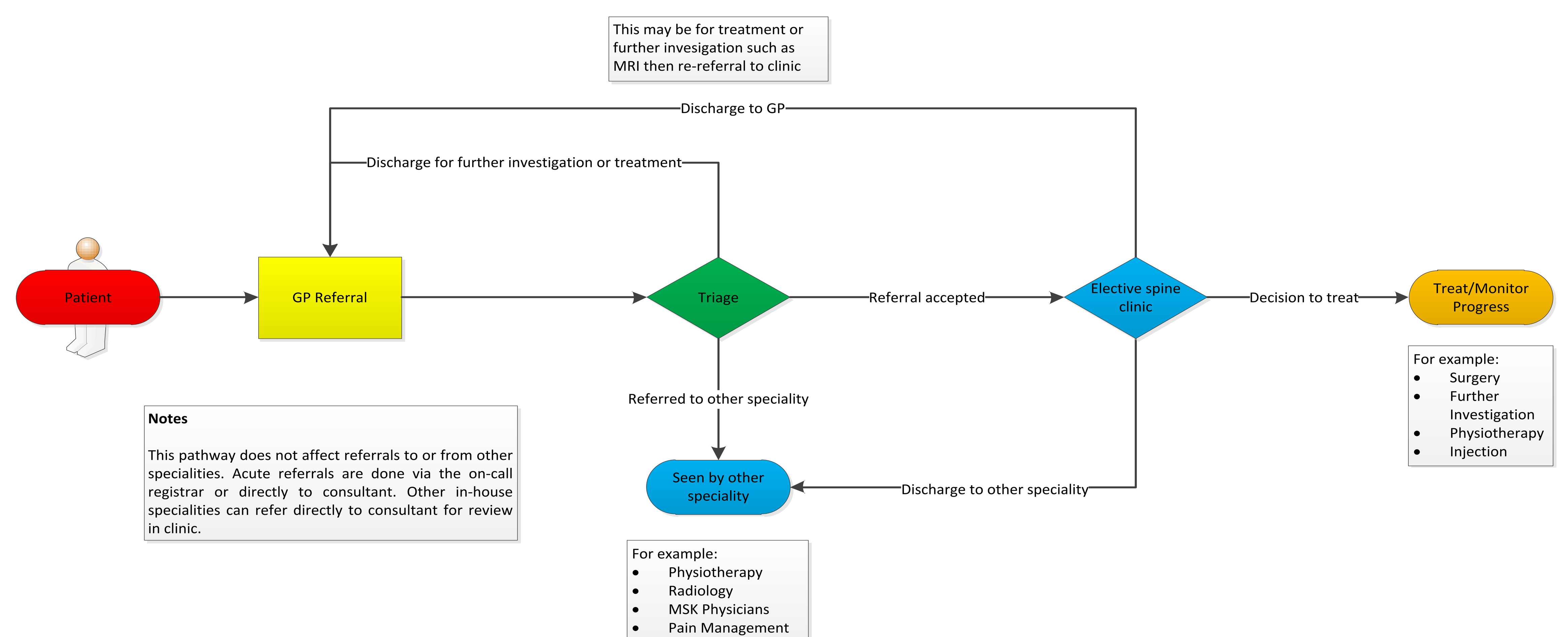
Triage Mechanism

Transition to the new system took place over a period of a few months with triage initially done by one surgeon – this is now done by a multidisciplinary team of MSK physicians and surgeons.

Referrals are triaged into urgency categories to ensure that the most urgent cases are seen first.

Patient are sent back to Primary Care only if it is deemed safe to do so i.e. there are no red flag symptoms or signs noted – these patients are seen on an urgent basis.

Non-urgent referrals without necessary investigations i.e. MRI, are required to be re-referred once done.



Outcomes

We performed a service assessment 1 year after introduction to see what effect the system was having. This was done via an audit of clinic letters, review of the scans, and to ensure it was safe we called GPs surgeries regarding each of the patients. We noted that waiting times did reduce on a month by month basis but could not directly attribute this to the triage system as a new consultant surgeon was employed by the trust shortly following introduction of the service. Instead we used a number of surrogate markers to measure the effect.

We sampled patients referred during a 6 month period. In this time a total of 512 patients were referred from GPs in the community. Overall **42 patients were discharged** (see table below for details). Seventy-seven were asked to be re-referred with MRI, **39 of these were not referred again**. The majority did not require re-referral (a small number were either awaiting investigation or an appointment). Additionally we compared the number of clinic appointments required, before a decision to treat was made, for those who had no MRI at their 1st appointment to those who did. This showed a **reduction in the number of appointments required per patient from an average of 1.6 to 1.3 respectively**. There were no adverse events noted during this 6 month period. The system has been shown to be robust, safe and has reduced both waiting times and the number of unnecessary clinic appointments. We learned that the introduction of effective filtering and pre-appointment investigation can safely and significantly reduce the burden on an overloaded system.

1. Spinal Taskforce for Department of Health. Organising Quality and effective spinal services for patients: a report for the local health communities by the Spinal Task Force. Department of Health, 2010

Future Developments

Electronic/online referrals
Roll-out across other specialities
Better information for GPs

Triage Outcomes

Triage Category	Number (n=512)	Percentage
Urgent	172	34
Routine	199	39
Soon	22	4
Discharge- further investigations	77	15
Discharge - refer to other speciality	24	5
Discharge - inappropriate referral	3	1
Discharge - further information required	3	1
Discharge -already under the care of other speciality/hospital	3	1
Discharge - send to physiotherapy	9	2

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